Home Health Certification and Plan of Care

Order ID: 1150/18349

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
MD00011020	04/28/2026	From: 04/28/2026 To: 06/26/2026	25204	217058

6. Patient's Name and Address
Louise Braggs
909 North Woodington Road,
Baltimore, MD 21229-
443-858-2981

7. Provider's Name, Address and Telephone Number
HomeCentris Healthcare LLC
10 Crossroads Drive, Suite 102
Owings Mills, MD 21117-8284
410-321-8448
1487113239

8. DOB 05/13/1942 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I48.0	Paroxysmal atrial fibrillation	04/28/26

13. ICD	Other Pertinent Diagnoses	Date
I48.92	Unspecified atrial flutter	04/28/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	04/28/26
I50.33	Acute on chronic diastolic (congestive) heart failure	04/28/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	04/28/26
N18.32	Chronic kidney disease stage 3b	04/28/26
D63.1	Anemia in chronic kidney disease	04/28/26
I42.9	Cardiomyopathy unspecified	04/28/26
J44.89	Other specified chronic obstructive pulmonary disease	04/28/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	04/28/26
E78.5	Hyperlipidemia unspecified	04/28/26
K21.9	Gastro-esophageal reflux disease without esophagitis	04/28/26
Z79.01	Long term (current) use of anticoagulants	04/28/26

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

Diltiazem Hydrochloride - Diltiazem Hydrochloride ER 300 mg / 1 Capsule by mouth one time a day for HTN Hold for SBP less than 110 and HR less than 60
ELIQUIS 5 mg / 1 Tablet by mouth two times a day for A-Fib
Hydralazine Hydrochloride - Hydralazine Hydrochloride 25 mg / 1 Tablet by mouth one time a day for HTN
JARDIANCE 10 mg / 1 Tablet by mouth one time a day for DM
Lasix - Furosemide 40 mg / 1 Tablet by mouth two times a day for CHF
Metoprolol Succinate - Metoprolol Succinate ER 200 mg / 1 Tablet by mouth one time a day for A-Fib Hold for SBP less than 110 and HR less than 60
MONTELUKAST SODIUM 10 mg / 1 Tablet by mouth one time a day for allergic rhinitis
Pantoprazole Sodium - Pantoprazole Sodium Delayed Release 40 mg / 1 Tablet by mouth one time a day for GERD
ROSUVASTATIN CALCIUM 20 mg / 1 Tablet by mouth at bedtime for HLD
VALSARTAN 160 mg / 1 Tablet by mouth one time a day for HTN
Multivitamin Oral Tablet (Multiple Vitamin) 1 Tablet by mouth once a day for vitamin deficiency
Albuterol Sulfate: Ipratropium Bromide - Albuterol Sulfate: Ipratropium Bromide Inhalation Solution 0.5-2.5 (3) MG/3ML / 3 ml inhale orally inhalant every 4 hours as needed for SOB/Wheezing
Trelegy Ellipta Inhalation Aerosol Powder Breath Activated (Fluticasone Umeclidinium-Vilanterol) 200-62.5-25 MCG/ACT / 1 puff inhale orally inhalant once a day for COPD
Lantus Solostar - Insulin Glargine Recombinant Pen injector 100 UNIT/ML / Inject 5 unit subcutaneous at bedtime for DM
Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML subcutaneous before meal and at bedtime for DM. Inject as per sliding scale: if 150 - 200 = 0 units BS less than 70 call MD; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401+ = call MD,

14. DME and Supplies:
cane, walker, diabetic supplies, bath bench

15. Safety Measures:
bleeding precautions, walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with device, medication safety, standard precautions, fall precautions, diabetic precautions

16. Nutrition:
diabetic

17. Allergies:
clopidogrel empagliflozin gabapentin hydrochlorothiazide meloxicam metformin

18.A. Functional Limitations
Endurance, Hearing, Ambulation, Bowel/Bladder Incontinence

18.B. Activities Permitted
Cane, Walker, Exercises Prescribed, Transfer bed/Chair, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Paroxysmal atrial fibrillation, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device.

Clinical Condition Requiring Homecare:
The patient is an 83-year-old female admitted to home health services with a complex past medical history including type 2 diabetes mellitus requiring insulin therapy, congestive heart failure, chronic obstructive pulmonary disease (not requiring home oxygen), gastroesophageal reflux disease, arthritis, atrial fibrillation and atrial flutter managed with Eliquis, history of syncope, cardiomyopathy, hyperlipidemia, chronic kidney disease, normocytic anemia, ambulatory dysfunction, and a history of right total knee replacement. The patient was recently discharged from Sinai Hospital following hospitalization for respiratory failure requiring non-invasive positive pressure ventilation (NIPPV), after which she completed a rehabilitation stay at Autumn Lake Healthcare at Summit Park before returning home. On assessment, the patient is alert and oriented, cooperative, and able to communicate needs appropriately. Vital signs were obtained and are within normal limits. Respiratory status is stable with clear lung sounds and no signs of respiratory distress or shortness of breath; the patient is not utilizing supplemental oxygen. Cardiovascular status is stable with no reports of chest pain, palpitations, or edema. Skin assessment revealed intact skin with no open areas or wounds. The patient remains homebound due to the significant effort required to leave the home and functional limitations. Functionally, the patient demonstrates generalized weakness and impaired mobility. She ambulates approximately 30 feet on level indoor surfaces with supervision using a straight cane and requires supervision for transfers, including sit-to-stand from bed, chair, and toilet, as well as for bed mobility. She is able to perform curb negotiation to exit the home with supervision, utilizing environmental supports such as the door and door frame. Outside ambulation and car transfer abilities were not assessed at this time. The patient's fall risk remains elevated, as evidenced by a Tinetti score of 15/28 and a recent history of falls, including a reported fall down stairs last year with incomplete recovery. She requires assistance with some activities of daily living. The patient resides alone in a duplex, with her sister living upstairs and her daughter nearby providing assistance with shopping, meals, and laundry. Medication reconciliation was completed with no discrepancies noted. The patient continues insulin therapy for diabetes management. Skilled nursing provided education on proper insulin administration, blood glucose monitoring via fingerstick, recognition and management of hypo- and hyperglycemia, adherence to a diabetic diet, and medication compliance. The patient demonstrated understanding but will require ongoing reinforcement. Additional

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 04/28/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Nana Ceasar
6501 Baltimore National Pike
Catonsville, MD 21228
PHONE: 667-234-2100 FAX: 14107445117 NPI: 1881704278

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
F2F date : 04/15/2026

27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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education was provided on management of chronic conditions, including heart failure and COPD, emphasizing symptom monitoring, hydration, energy conservation, and when to notify the physician of any worsening condition. Fall prevention strategies and home safety measures were also reviewed. Occupational and physical therapy evaluations indicate the patient would benefit from continued skilled therapy services to improve strength, balance, functional mobility, and independence with activities of daily living, with the goal of reducing fall risk and restoring prior level of function. Skilled nursing services remain medically necessary for continued cardiopulmonary assessment, diabetic management, medication education, safety monitoring, and prevention of further functional decline and rehospitalization.
 Date of Order 04/28/2026 Orders Physician Face-to-Face Date: 04/15/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Paroxysmal atrial fibrillation Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc OT Eval Notes: PT Eval Notes: Physician Ceasar, Nana

SN Careplans

SN WK1: 1 (04/28/26-05/02/26) ,WK2: 1 (05/03/26-05/09/26) ,WK3: 1 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/22/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.
Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.
Provide education content at patient's level of health literacy.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.
Assess: Musculoskeletal status.
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, M1400 - Dyspnea, M1610 - Urinary Incontinence, limited endurance, limited strength, B1000 - Vision Deficit, weak hand grips, Pain Interference with ADLs, Pain Interference with Therapy activities, B0200 - Hearing Deficit, balance deficit, obesity

PROCEDURES: glucose testing via monitor, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation

SN Goals

PATIENT-STATED GOAL: Patient stated she wants to learn how to take her insulin on her own

GOALS
patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/28/2026

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treatments with adequate competence

PT Careplans

PT WK1: 1 (04/28/26-05/02/26) ,WK2: 1 (05/03/26-05/09/26) ,WK3: 1 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/22/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair

PROCEDURES: cough/deep breathing exercises, home exercise program: Supine hip flexion, bridging, hooklying, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Car Transfer - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: To be able to do the front steps to exit the house by myself

GOALS
Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Car Transfer - 05. Setup or clean-up assistance

OT Careplans

OT WK1: 6 (04/28/26-05/02/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, M1400, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing

PROCEDURES: cough/deep breathing exercises, incentive spirometer, home exercise program: Cane exercises: bilateral shoulder flex chest presses horizontal abd 2x5 reps, equipment training, work simplification/energy conservation, transfers training

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Car Transfer - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: To get stronger

GOALS
Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/28/2026

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Car Transfer - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
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