Home Health Certification and Plan of Care

Order ID: 1150/18797

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2QV0QV1CE90	05/19/2026	From: 05/19/2026 To: 07/17/2026	25747	217058

6. Patient's Name and Address

Deborah Richardson
4557 Hidden Stream Ct,
Owings Mills, MD 21117-
443-226-1675

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 05/09/1953 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I50.9	Heart failure unspecified	05/19/26

13. ICD	Other Pertinent Diagnoses	Date
I48.92	Unspecified atrial flutter	05/19/26
I48.91	Unspecified atrial fibrillation	05/19/26
I27.0	Primary pulmonary hypertension	05/19/26
E11.9	Type 2 diabetes mellitus without complications	05/19/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	05/19/26
M62.59	Muscle wasting and atrophy NEC multiple sites	05/19/26
J44.9	Chronic obstructive pulmonary disease unspecified	05/19/26
E87.6	Hypokalemia	05/19/26
E83.42	Hypomagnesemia	05/19/26
E46.	Unspecified protein-calorie malnutrition	05/19/26
R41.841	Cognitive communication deficit	05/19/26
L30.4	Erythema intertrigo	05/19/26
Z79.4	Long term (current) use of insulin	05/19/26
Z79.01	Long term (current) use of anticoagulants	05/19/26
Z79.82	Long term (current) use of aspirin	05/19/26
Z87.440	Personal history of urinary (tract) infections	05/19/26

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

ALBUTEROL HFA 108 (90 Base) MCG/ACT / Give 2 puff by mouth every 4 hours for COPD RINSE MOUTH AFTER USE
AMIODARONE 200 mg / 1 Tablet by mouth one time a day for ATRIAL FLUTTER
Aspirin - Aspirin Chewable 81 mg / 1 Tablet by mouth once a day for CVA prophylaxis
ATORVASTATIN 40 mg / 1 Tablet by mouth at bedtime for HYPERLIPIDEMIA
BUMETANIDE 2 mg 2 mg / 1 Tablet by mouth two times a day for CHF
DIGOXIN 125 mcg / 1 Tablet by mouth one time a day for A-Fib HOLD FOR HR LESS THAN 60
Fluticasone-Salmeterol Aerosol Powder, breath activated 250-50 MCG/ACT / 1 Inhalation by mouth twice a day for COPD
Metoprolol Tartrate - Metoprolol Tartrate 50 mg / 1 Tablet by mouth two times a day for HTN Hold for sbp less than 110, HR-60
Simethicone - Simethicone 125 mg / 1 Capsule by mouth three times a day for bloating, gas
Tylenol - Acetaminophen 325 mg 325 mg/tablet / Give 2 tablet by mouth every 8 hours as needed for pain DO NOT EXCEED 3G/24HR
SPIRONOLACTONE 25 mg 25 mg / 1 Tablet by mouth one time a day for CHF

14. DME and Supplies:

walker

15. Safety Measures:

walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, medication safety, standard precautions, fall precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Transfer bed/Chair, Walker, Exercises Prescribed, 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: Yes

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Heart failure unspecified, 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 a 72-year-old female admitted to home health services following recent hospitalization, subsequent skilled nursing facility rehabilitation stay, and ongoing recovery from multiple cardiopulmonary and functional impairments. Her past medical history is significant for congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, coronary artery disease (CAD), pulmonary hypertension, muscle wasting and atrophy, unspecified protein-calorie malnutrition, atrial flutter with rapid ventricular response (RVR), hypotension requiring ICU admission with Levophed support, pulmonary edema, and ambulatory dysfunction with generalized deconditioning. The patient was initially hospitalized in February for fluid overload and cardiopulmonary complications, briefly returned home, and subsequently required rehospitalization followed by subacute rehabilitation placement. She is currently staying with her daughter during the recovery period, although she normally resides with her husband in a townhouse and was previously independent with basic self-care tasks and mobility. Upon assessment, the patient was alert and oriented x4 with no apparent distress noted. Vital signs were within acceptable limits at the time of visit. The patient ambulates with a walker and requires assistance for safety secondary to generalized weakness, impaired endurance, decreased activity tolerance, impaired balance, and gait instability. No skin breakdown, open wounds, or other integumentary concerns were observed during the visit. Functional decline following prolonged hospitalization and rehabilitation has significantly impacted the patient's tolerance for mobility and activities of daily living, requiring frequent rest breaks and implementation of energy conservation strategies due to cardiopulmonary limitations and exertional fatigue. The patient demonstrates increased fall risk related to weakness, impaired endurance, decreased balance, and reduced safety awareness during transfers and ambulation. Skilled nursing education was provided regarding medication compliance, heart failure management, monitoring for worsening edema, shortness of breath, sudden weight gain, and signs and symptoms of CHF or COPD exacerbation requiring physician notification. Additional teaching included importance of proper nutrition and hydration, maintaining adequate protein and caloric intake related to malnutrition and muscle wasting, energy conservation techniques, breathing strategies, and fall prevention measures. The patient demonstrated understanding of the education provided, though reinforcement will continue as needed during future <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh>. Physical therapy evaluation identified generalized weakness, decreased endurance, impaired gait mechanics, impaired transfers, balance deficits, reduced activity tolerance, and overall decline in functional mobility following recent hospitalization and medical complications. Skilled home health physical therapy services are medically necessary to address gait training, transfer training, balance retraining, therapeutic exercise, endurance conditioning, fall prevention, breathing techniques, energy conservation education, and development of a home exercise program to maximize safety and restore functional independence while reducing risk of rehospitalization. Occupational therapy evaluation further revealed deficits in activities of daily living, functional mobility, activity tolerance, homemaking tasks, and safety awareness. The patient would benefit from ongoing skilled occupational therapy services every other week to address ADL retraining, therapeutic exercise, home exercise program instruction, functional mobility training, homemaking tasks, and home safety training to improve independence and quality of life during recovery. The

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/19/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Ayesha Gulistan
120 Westminster Pike Ste 104
Reisterstown, MD 21136
PHONE: 4105263053 FAX: 14105842240 NPI: 1609105386

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 : 04/21/2026

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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patient remains homebound due to significant weakness, impaired endurance, cardiopulmonary limitations, fall risk, and need for assistance and assistive devices for safe mobility outside the home. Continued skilled nursing, physical therapy, and occupational therapy services remain medically necessary to support cardiopulmonary stability, functional recovery, nutritional management, safety, and prevention of further decline or rehospitalization.
 Date of Order 05/19/2026 Orders Physician Face-to-Face Date: 04/21/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Heart failure unspecified 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 PT Eval Notes: OT Eval Notes:
 Physician Gulistan, Ayesha

SN Careplans

SN WK1: 1 (05/19/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK6: 1 (06/21/26-06/27/26)

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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, M2102f - Patient Supervision, meal preparation, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, muscle weakness, limited endurance, limited strength, limited range of motion, difficulty sleeping, weak hand grips, B1000 - Vision Deficit

PROCEDURES: teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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 treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: Patient states she wants to feel better

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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* 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 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/19/2026

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PT Careplans

PT WK1: 1 (05/19/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK6: 1 (06/21/26-06/27/26) ,WK7: 1 (06/28/26-07/04/26) ,WK8: 1 (07/05/26-07/11/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car 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, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Medication Review-: Patient verbalized understanding of current prescriptions, dosages, and schedule. No reported issues with adherence, side effects, or confusion at this time., B LE strengthening: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day., gait training/stair training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT Goals

PATIENT-STATED GOAL: not to go back to hospital

GOALS
Chair to Bed to Chair - 06. Independent

Sit to Stand - 06. Independent

Toilet Transfer - 05. Setup or clean-up assistance

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK1: 1 (05/19/26-05/23/26) ,WK3: 1 (05/31/26-06/06/26) ,WK5: 1 (06/14/26-06/20/26) ,WK7: 1 (06/28/26-07/04/26) ,WK9: 1 (07/12/26-07/17/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, 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, home exercise program: 16 oz water bottle: bilateral shoulder flex, chest presses, horizontal abd/add, bicep curls 2x10 reps., equipment training, work simplification/energy conservation, dynamic standing balance exercises: As needed, transfers training: tub

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, 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
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

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

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
05/19/2026