HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022115

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
7NV6A94EH51	09/16/2026	09/16/2026 - 11/14/2026	30324	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Valerie Gaine 9300 FITZHARDING LANE OWINGS MILLS, MD 21117	Female	08/05/1960	410-409-2764
	Email gaine@comcast.net		**Primary Language** English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI 1487113239		**Fax Number** 410-559-3002

Clinical Condition Requiring Homecare:

The patient is a 66-year-old female who was recently hospitalized for failure to thrive, abdominal pain, and dysphagia and has been referred for home health services, including skilled nursing for education, disease management, and medication teaching, as well as home PT and OT evaluation and treatment. Past medical history is significant for cerebrovascular accident (CVA), anxiety/depression, GERD, and hyperlipidemia. The patient resides with her husband and has a caregiver available during the daytime. She is considered homebound due to generalized weakness and functional decline, requiring assistance with ambulation and use of a two-handed assistive device. Upon assessment, the patient denied chest pain, headache, nausea, vomiting, fever, or chills. Lung sounds were clear to auscultation. Abdomen was flat with normoactive bowel sounds, and last bowel movement was yesterday. The patient reported voiding without difficulty. No edema was noted, and pedal pulses were present. Vital signs were within acceptable parameters. No wounds were observed. Medication reconciliation was completed, and the patient and caregiver were educated regarding medication effects and potential adverse reactions. The patient required redirection during the visit; therefore, continued teaching with the husband and caregiver present is recommended to reinforce understanding, adherence, and safety. The patient, husband, and caregiver were educated regarding home safety, decluttering, and maintaining an appropriate and safe home environment to reduce risks associated with the patient's functional decline and impaired mobility. All parties verbalized understanding of the education provided. Skilled nursing will continue to provide disease management, medication teaching, monitoring, and reinforcement of safety education. Home PT and OT evaluations and treatment are ordered to address generalized weakness, functional decline, impaired mobility, and decreased independence with daily activities, with the goal of improving safety and functional independence in the home.

Physician Statement on Homebound Status:

Due to diagnosis of Pyonephrosis, 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.

Date of Order
09/16/2026
Orders
Physician Face-to-Face Date: 09/14/2026
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease mangement pt-eval & treat ot-eval & treat due to Pyonephrosis
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

Physician
Colodonato, Julie

ICD-10 CM Principal Diagnosis: N13.6. Pyonephrosis

Other Pertinent Diagnoses

ICD-10 CM	Description
M81.0	Age-related osteoporosis w/o current pathological fracture
M85.80	Oth disrd of bone density and structure unspecified site
G62.9	Polyneuropathy unspecified
E43.	Unspecified severe protein-calorie malnutrition
H40.1191	Primary open-angle glaucoma unspecified eye mild stage
D72.829	Elevated white blood cell count unspecified
F41.9	Anxiety disorder unspecified
F32.A	Depression unspecified
F39.	Unspecified mood [affective] disorder
M41.9	Scoliosis unspecified
E87.6	Hypokalemia
E87.1	Hypo-osmolality and hyponatremia
E78.5	Hyperlipidemia unspecified
K21.9	Gastro-esophageal reflux disease without esophagitis
G47.00	Insomnia unspecified
Z86.0100	Personal history of colonic polyps
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits

Medications

Calcium Carbonate Antacid 1000 MG Chew / Take 1,000 mg by mouth twice a day for 7 days.
DICYCLOMINE 10 MG Capsule / Take 2 capsules by mouth four times a day for 7 days. Commonly known as: BENTYL
MIRTAZAPINE 7.5 MG / 1 Tablet by mouth in the evening Commonly known as: REMERON
PANTOPRAZOLE Delayed Release 40 MG / 1 Tablet by mouth twice a day Commonly known as: PROTONIX
GABAPENTIN 300 MG capsule / Take 2 capsules by mouth in the evening Commonly known as: NEURONTIN
CLONAZEPAM Take 2 MG Tablet by mouth nightly as needed. Commonly known as: KlonoPIN
Dorzolamide Hydrochloride And Timolol Maleate - Dorzolamide Hydrochloride: Timolol Maleate 2-0.5 % Soln / Place 1 drop both eyes twice a day Commonly known as: COSOPT-PF
MIRALAX 17 g packet / Take 17 g by mouth once a day Stir and dissolve 1 packet in any 4-8 ounces of non-carbonated beverage. Generic drug: polyethylene glycol
ROSUVASTATIN CALCIUM 5 MG / 1 Tablet by mouth EVERY DAY Commonly known as: CRESTOR
TIMOLOL 0.5 % ophthalmic solution / Place 1 drop both eyes in the evening Commonly known as: TIMOPTIC
MELATONIN 3 MG by mouth nightly. Insomnia
VITAMIN E PO 50,000 by mouth once a day
LUTEIN 10 MG Tabs by mouth once a day
VITAMIN D PO 3,000 Units. by mouth once a day

Prognosis
good

Mental and Psychosocial Status
COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

Functional Limitations
Dyspnea With Minimal Exertion, Endurance, Ambulation

Activities Permitted
Walker, Up As Tolerated

DME & Supplies
walker, hand held shower, bath bench

Safety Measures
smoke detectors , emergency phone # clearly displayed, ambulates with assistance, bathroom safety, hand rails, supervision at all times, transfer with assist, standard precautions, walker precautions, medication safety, fall precautions, avoid temperature extremes, ambulates with device, activity supervision

Nutrition
regular

Allergies
lactose intolerance

Advance Directives	Caregiver Status
Refused	3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance; 2. Non-agency caregiver(s) need training/supportive services to provide assistance
Rehabilitation Potential	**DISCHARGE PLAN:**
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.	SN: family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

SN CAREPLAN

SN frequency WK1: 1 (09/16/26-09/19/26),WK2: 2 (09/20/26-09/26/26),WK3: 2 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26),WK7: 1 (10/25/26-10/31/26),WK9: 1 (11/08/26-11/14/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

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:Refused

09/16/2026 Problems : inadequate trash/sewage disposal (CM)
cluttered/soiled living area (CM)
unsafe floor coverings (CM)
abnormal blood pressure (CR)
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with Therapy activities

SN NARRATIVE

Patient was sent to the hospital for failure to thrive, abdominal pain, dysphagia. Home health service ordered for Skilled Nursing (Education, Disease Mgmt, Medication Teaching), Home PT Eval and Treat, Home OT Eval and Treat. Patient is homebound due to generalized weakness and functional decline, requires assistance with ambulation and use a two-handed device. Patient lives with husband and have caregiver during the day.

Patient is a 66 y.o. female with past medical history significant for CVA,

anxiety/depression, GERD, hyperlipidemia.. Patient denies chest pain, headache, nausea and vomitting, fever/chills. Patient lungs clear on auscultation abdomen flat with normoactive bowel sounds LBM yesterday. Void with no difficulties, no edema, pedal pulse present. Patient vital signs within acceptable parameters. Patient medication reconciliation completed, patient and caregiver educated on medication effects and adverse reaction. Patient had to be redirect, it would be most beneficial to provide teaching with husband and caregiver present. Patient educated on home safety, decluttering and improving the overall condition of the home. Patient, husband and caregiver verbalized understanding of all teaching. No wounds

SN GOALS

PATIENT-STATED GOAL: I want to reclaim my independence;Keep my home clean

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

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
* 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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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

patient living environment has safe floor coverings

patient's living environment is clean/uncluttered

patient has access to adequate trash/sewage disposal

Pain Interference with ADLs M1400 - Dyspnea M2020 - Oral Med Management abn cholesterol > 200 mg/dL balance deficit lethargy difficulty sleeping daytime fatigue limited endurance limited strength muscle weakness abdominal pain heartburn/indigestion constipation loss of appetite swell/redness surround. skin B1000 - Vision Deficit M2102c - Med Admin D0160 - Depression M2102f - Patient Supervision M2102d - Caregiver Performs Treatment PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange repair of unsafe floor coverings, coordinate/arrange for maintenance of clean/uncluttered living area, coordinate/arrange resources for vision-impaired 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, 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 living environment has safe floor coverings, patient's living environment is clean/uncluttered, patient has access to adequate trash/sewage disposal, caregiver administers and/or packages medications appropriately	caregiver administers and/or packages medications appropriately

	PT GOALS

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/16/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services. F2F date: 09/14/2026	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.
Certifying Physician or Allowed Practitioner Name and Address **Julie Colodonato** 7505 Osler Dr Towson, MD 21204 NPI 1831233238	**Phone Number** 4104272575 **Fax Number** 14104272576

Physician's Signature and Date Signed

X

Julie Colodonato, MD
09/14/2026: Date of physician last face-to-face