HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022133

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
12323948	09/16/2026	09/16/2026 - 11/14/2026	30392	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Joyce Owens 5310 Beaufort Avenue BALTIMORE, MD 21215	Female	06/26/1947	410-419-9884
	Email		**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:

Skilled nursing admission was completed, and consents were signed by the patient. The patient is a 79-year-old female with anemia and chronic kidney disease (CKD) receiving oncology monitoring for thalassemia, an inherited blood disorder associated with anemia. The patient requires ongoing blood draws for CBC and iron monitoring, with the patient and caregiver reporting a history of blood draws every four weeks; however, no current laboratory orders were noted, and the patient and caregiver reported that the last blood draw was in April. The nurse communicated with Clinical Manager Shannon L. regarding the patient's admission and laboratory monitoring needs. The patient is being admitted to skilled nursing services for medication management and disease process management. The patient's daughter, Charlotte, is the caregiver and POA. A medication list was reviewed and written for quick reference, and the calendar was completed for future scheduling. The patient is alert and oriented x3-4 and reports approximately 5/10 knee pain related to arthritis. She reports using witch hazel applied to a cloth and placed on the knee, which she states provides effective pain relief. Medication reconciliation and review were completed with the patient and caregiver, including medication actions and potential side effects, with understanding reinforced. The patient denies recent falls and reports significant difficulty with ambulation. She requires maximum assistance with transfers and ambulation, making leaving the home a taxing effort. The patient reports that diuretic therapy has greatly decreased edema in the lower extremities, with loose skin noted to the lower extremities. No open wounds were observed. No abnormal bleeding was reported, and the patient has a history of receiving iron infusions. The patient sleeps on an adjustable bed with a railing and has a commode, wheelchair, cane, and walker available in the home. She uses incontinence wear for occasional accidents. Last bowel movement was yesterday, and she denies abdominal discomfort. The patient reports a good appetite and no discomfort with urination. She reports sleeping adequately

Physician Statement on Homebound Status:

Due to diagnosis of Iron deficiency anemia 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.

and states that she sleeps better while sitting upright, noting that she has begun to fall asleep in bed while lying down. No abnormal lung sounds were noted on assessment. Fluid restrictions were discussed, including the importance of monitoring all liquids consumed. The patient and caregiver verbalized understanding of the education provided. Insurance was verified, and no other agency is currently providing services in the home. Skilled nursing will continue to monitor the patient's anemia, CKD, thalassemia, medication regimen, fluid status, edema, pain, bleeding risk, and overall disease process, as well as coordinate laboratory monitoring and reinforce disease-management and safety education.

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 management due to Iron deficiency anemia 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

Physician
Wajahat, Neelofar

ICD-10 CM Principal Diagnosis: D50.9. Iron deficiency anemia unspecified

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
D56.3	Thalassemia minor	GLUCOTROL 5 MG Tablet / Take half tablet by mouth twice a day 30 minutes before meals PROTONIX TBEC DR 40 MG / 1 Tablet by mouth 2 times a day Toprol-Xl - Metoprolol Succinate 24hr SR 25 MG / 1 Tablet by mouth daily TEMOVATE 0.05 % Top Ointment / Apply to spots topical as necessary twice a day for 2 weeks PACERONE 200 MG / 1 Tablet by mouth daily Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50 mcg (2,000 unit) Capsule / Take 2,000 Units by mouth once a day Centrum Silver - Ascorbic Acid: Biotin: Cyanocobalamin: Ergocalciferol: Folic Acid: Niacinamide: Pantothenic Acid: Phytonadione: Pyridoxine: Ribo 0.4 mg-300 mcg -250 mcg / 1 Tablet by mouth daily VITRON-C TBEC DR 65 mg iron- 125 mg / 1 Tablet by mouth once a day Torsemide - Torsemide 20 MG Tablet / Take 3 to 4 tablets by mouth once a day Diuretic Albuterol Nebulizer - Albuterol 0.083% inhalant as necessary Asthma Trazadone - Trazodone Hydrochloride 50mg by mouth at bedtime

Prognosis
fair

Mental and Psychosocial 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

Functional Limitations
Bowel/Bladder Incontinence, Ambulation, Endurance

Activities Permitted
Exercises Prescribed, Up As Tolerated, Transfer bed/Chair, Wheelchair, Walker

DME & Supplies	Safety Measures
grab bars, diabetic supplies, walker, wheelchair, nebulizer, cane, commode	smoke detectors , emergency phone # clearly displayed, , bathroom safety, hand rails, diabetic precautions, wheelchair precautions, walker precautions, transfer with assist, supervision at all times, standard precautions, medication safety, fall precautions, ambulates with device, ambulates with assistance, activity supervision
Nutrition	**Allergies**
diabetic, low sodium	hydralazine hydrochloride sulfa antibiotics

Advance Directives	Caregiver Status
Charlotte Whiteside	2. Non-agency caregiver(s) need training/supportive services to provide assistance; 2. Non-agency caregiver(s) need training/supportive services to provide assistance
Rehabilitation Potential	**DISCHARGE PLAN:**
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.	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: 1 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26),WK6: 1 (10/18/26-10/24/26)

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, 9. Other risk(s) not listed in 1- 8

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; 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 ; 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.

No open wounds noted
Advance Directive:Charlotte Whiteside

09/18/2026 Problems : frequent urination (GU)
A1250 - Lack of Necessary Transportation
Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
abnormal blood pressure
pain radiating to arms/legs
weak hand grips
balance deficit

SN NARRATIVE

Anemia and CKD with oncology monitoring with ambulatory difficulty requiring max assist with ambulation making it a taxing effort to leave the home

Consents signed by patient. Caregiver POA is daughter Charlotte. Medication list written for quick reference. Calendar complete to future .

Patient is alert and oriented x3-4. Patient is 79 yo female with oncology monitoring with blood draws for CBC and iron for Thalassemia (inherited blood disorder and anemla. No lab orders noted. Nurse spoke with Clinical Manager Shannon L. Admission to services for medication management and disease process management. Patient history states blood draw every 4 weeks. Last blood draw per patient and caregiver was in April. Patient complained of Knee pain with arthritis about 5/10. PATIENT reports she uses with hazel applies to cloth an apply to knee, effective for pain relief. Patient medications reviewed with patient and caregiver for understanding of medications actions and side effects. No falls reported. Patient requires maximum assistance with transfers. Patient reports ambution difficulty. Patient reports diuretic therapy decrease edema greatly from lower extremities. Loose skin noted to lower extremities. No open wounds noted on assessment. Patient sleeping on adjustable bed with railing. Commode, wheelchair cane walker noted in the home. Incontinence wear for accidents. Last bowel movement was yesterday. No abdominal discomfort reported. Patient reports good appetite. Discussed fluid RESTRICTIONS with all liquids consumed. No discomfort with urination reported. Patient reports sleeping okay. Patient reports sleeping better sitting up right, she began to fall asleep in the bed while laying down. Insurance verified. No other agency in the home. No Abnormal lung sounds noted. No Abnormal bleeding reported. Patient past iron infusions administered.

SN GOALS

PATIENT-STATED GOAL: To increase strength to LE

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 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

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

poor muscle tone
muscle weakness
swelling of affected area
limited endurance
limited range of motion
limited strength
heartburn/indigestion
obesity
itchy skin
discolored patches of skin
B1000 - Vision Deficit
meal preparation
M2102c - Med Admin
M2102f - Patient Supervision
M2102d - Caregiver Performs Treatment
M1610 - Urinary Incontinence

PROCEDURES: cough/deep breathing exercises, monitor intake & output, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals, 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, * urinary incontinence management including bladder training Kegel exercises skin 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, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately

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 **Neelofar Wajahat** 7141 Security Blvd Baltimore, MD 21244 NPI 1083861181	**Phone Number** 855-902-4974 **Fax Number** 14108473396

Physician's Signature and Date Signed

X

Neelofar Wajahat
09/14/2026: Date of physician last face-to-face