Home Health Certification and Plan of Care

Order ID: 1150/12242

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
181006989	09/16/2025	From: 09/16/2025 To: 11/14/2025	17461	217058

6. Patient's Name and Address

Joyce Gary
101 Chesley Ave,
BALTIMORE, MD 21206-
410-665-9563

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 02/27/1951 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
U07.1	COVID-19	09/16/25

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	09/16/25
K21.9	Gastro-esophageal reflux disease without esophagitis	09/16/25
E78.2	Mixed hyperlipidemia	09/16/25
I70.0	Atherosclerosis of aorta	09/16/25
M17.0	Bilateral primary osteoarthritis of knee	09/16/25
E66.01	Morbid (severe) obesity due to excess calories	09/16/25
Z86.0100	Personal history of colonic polyps	09/16/25
Z85.43	Personal history of malignant neoplasm of ovary	09/16/25
Z90.710	Acquired absence of both cervix and uterus	09/16/25
Z91.81	History of falling	09/16/25

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

Tylenol - Acetaminophen take 500 mg tablet by mouth every 6 hours 500mg, Oral, every 6 hours PRN. Pt taking every morning for pain mgmt
calcium carbonate take 1,000 mg tablet by mouth three times a day 1,000 mg, Oral, 3X daily. Patients complaint with Med regimen
Amlodipine - Amlodipine Besylate take 2.5 mg tablet by mouth once a day 2.5 mg, Oral, 1X daily. Patients complaint with Med regimen and understands Med indication is for HTN
Pantoprazole - Pantoprazole Sodium take 40 mg tablet by mouth once a day 40 mg, Oral, 1X daily. Patients complaint with Med regimen and understands Med indication is for her clarification is needed as d/c paperwork says to take 2x daily but med bottle states 1x daily. PT has been taking it 1x daily.
Folic Acid - Folic Acid take 1 mg tablet by mouth once a day 1 mg, Oral, 1X daily for anemia. PT is compliant with med regimen and understands the indication.
Multivitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox take 1 tablet by mouth once a day 1 tablet, Oral, 1X daily. "I take one daily"
Mobic - Meloxicam take 7.5 mg tablet by mouth once a day 7.5 mg, 1 time daily. PT taking as needed for back pain.
Melatonin - Melatonin 10mg by mouth at bedtime Patient takes it as needed for sleep
Meclizine Hydrochloride - Meclizine Hydrochloride 25 mg by mouth as necessary Patient states "I usually take 1 in the morning for dizziness"
Phenol 1.4% Throat spray 1.4% by mouth once a day Prescribed while pt was in the hospital for sore throat. Pt is no longer taking it, stating "i don't need it my throat is better."
Protonix - Pantoprazole Sodium take 40 mg tablet by mouth twice a day 40 mg, Oral, 2 times daily. Patients compliant with Med regimen and understands Med indication is for her clarification is needed as d/c paperwork says to take 2x daily but med bottle states 1x daily. PT has been taking it 1x daily. Dr will be called to clarify
Neurontin - Gabapentin take 600 mg tablet by mouth three times a day 600 mg, Oral, 3 times daily. She complains that taking it 3x daily makes her "dizzy". clarification for required dose needed from physician.
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000 u by mouth once a day 1x daily supplement

14. DME and Supplies:

grab bars, walker, cane

15. Safety Measures:

walker precautions, standard precautions, restricted ROM, remove environmental barriers, medication safety, medical alert/lifeline, knee precautions, hand rails, fall precautions, bathroom safety, ambulates with device, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

statins sulfa antibioticss

18.A. Functional Limitations

Bowel/Bladder Incontinence, Endurance

18.B. Activities Permitted

Exercises Prescribed, Walker, Cane, Partial Weight Bearing, Up As Tolerated, Transfer bed/Chair

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: 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

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

Homebound status: Due to diagnosis of Covid-19 , 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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 09/16/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Alyssa Mathew
4920 Campbell Blvd
Baltimore, MD 21236
PHONE: FAX: NPI: 1144640269

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 : 09/12/2025

27. Attending Physician's Signature and Date Signed **09/22/2025**: 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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Clinical Condition Requiring Homecare:

The patient is a 75-year-old female referred to home healthcare services by her physician following discharge from the University of Maryland St. Joseph Medical Center after sustaining a fall on 9/10/25. She has a past medical history significant for morbid obesity, bilateral knee pain, and generalized weakness. At the time of assessment, she was alert and oriented 4, well-groomed, and cooperative. She denied acute pain but reported mild generalized discomfort upon waking. Vital signs were within normal limits. Lung sounds were clear, bowel sounds were normal, and skin was intact except for a bruise below the left arm of unknown origin, which was photographed for documentation. Pedal pulses were weak bilaterally with 2+ pitting edema noted in both feet and ankles. The patient's primary complaints included weakness and limited endurance in her lower extremities, describing her legs as feeling "numb, like cement" with prolonged standing. She ambulates with a walker and cane, demonstrating an unsteady gait and easy fatigability, requiring frequent rest. She reported urinary frequency with nocturnal incontinence requiring adult briefs, as well as bowel incontinence occurring several times weekly. She lives with her spouse in a single-family home that is cluttered with narrow pathways, creating a safety hazard for ambulation. Bathroom assessment revealed a walk-in tub without supportive handrails and no railings at the toilet, placing her at increased fall risk despite her reported adaptation. Medication review revealed discrepancies: Gabapentin 600 mg TID was present in the home while the chart listed Gabapentin 300 mg TID, Phenol throat spray 1.4% was on hand though no longer in use, and her Pantoprazole bottle indicated once-daily dosing while discharge paperwork instructed twice daily. The RN planned to clarify orders with the primary care provider. Therapeutic exercises initiated included long arc quads with a yellow resistance band, knee abduction/adduction with a yellow band, side kicks, mini squats, and heel raises, each performed for 102 repetitions. The patient ambulated up to 20 feet with a rolling walker and assistance. Education was provided on home safety, safe ambulation techniques, the importance of strengthening and endurance training, fall prevention strategies, and medication adherence. The patient will continue to benefit from skilled nursing and physical therapy services to address strength, balance, endurance, and safety concerns with the goal of maximizing independence and reducing fall risk.
 Date of Order 09/16/2025 Orders Physician Face-to-Face Date: 09/12/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management PT-eval & treat OT-eval & treat due to Covid-19 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: Physician Mathew, Alyssa

SN Careplans

SN WK1: 2 (09/16/25-09/20/25) ,WK2: 1 (09/21/25-09/27/25) ,WK3: 1 (09/28/25-10/04/25) ,WK4: 1 (10/05/25-10/11/25)

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), 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 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
Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, Home Safety, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M1400 - Dyspnea, M1033 - Exhaustion, swelling in legs/around eyes, weak pulses in feet, M1620 - Bowel Incontinence, heartburn/indigestion, M1610 - Urinary Incontinence, limited strength, limited endurance, muscle weakness, limited range of motion, swelling of affected area, B1000 - Vision Deficit, balance deficit, Pain Interference with ADLs, discolored patches of skin

PROCEDURES: Medications reviewed with patient/ caregiver on each visit: Medications reviewed with patient/ caregiver on each visit, cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange for maintenance of clean/uncluttered living area

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * 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, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * low-fat diet lifestyle modifications to manage esophageal condition, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * how to help resolve infection including hygiene proper hand washing food-safety techniques travel precautions vaccinations animal-control cough etiquette, related medication(s) purpose, schedule, * how to manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, 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

SN Goals

PATIENT-STATED GOAL: "I want to be able to do regular things like stand in church and stand in the kitchen with my legs bothering me."

GOALS
patient/caregiver recalls
* how to manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* recalls related medication(s) purpose, schedule

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

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls
* low-fat diet
* lifestyle modifications to manage esophageal condition
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to help resolve infection including hygiene
* proper hand washing
* food-safety techniques
* travel precautions
* vaccinations
* animal-control
* cough etiquette
* 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
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/16/2025

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medication(s) purpose, schedule, patient's living environment is clean/uncluttered, 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

* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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's living environment is clean/uncluttered

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 10 (09/16/25-09/20/25), WK2: 2 (9/21/25-9/27/25), WK3: 2 (9/28/25-10/4/25), WK4: 1 (10/5/25-10/11/25) WK5: 1 (10/12/25-10/18/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, 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

PROCEDURES: Medication Review: The medication was reviewed with the patient, Home exercises : Slr, long arc , marching, side kicks --10x2 reps , cough/deep breathing exercises, incentive spirometer, 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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: The patient wants to get stronger and walk betetr

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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 - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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