Home Health Certification and Plan of Care

Order ID: 1150/14940

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
33293720	12/13/2025	From: 12/13/2025 To: 02/10/2026	20478	217058

6. Patient's Name and Address
Dorothy Benson
1106 Woodlawn Ave,
PASADENA, MD 21122-
443-422-7504

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 07/17/1951 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
N39.0	Urinary tract infection site not specified	12/13/25

13. ICD	Other Pertinent Diagnoses	Date
E11.9	Type 2 diabetes mellitus without complications	12/13/25
I10.	Essential (primary) hypertension	12/13/25
E78.5	Hyperlipidemia unspecified	12/13/25
E03.9	Hypothyroidism unspecified	12/13/25
F32.9	Major depressive disorder single episode unspecified	12/13/25
E88.89	Other specified metabolic disorders	12/13/25
Z87.19	Personal history of other diseases of the digestive system	12/13/25
Z91.81	History of falling	12/13/25
Z87.891	Personal history of nicotine dependence	12/13/25

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

Norvasc - Amlodipine Besylate eq 2.5 mg base 2.5 MG; 3 TABS by mouth once a day 7.5 mg, 1 time daily
BLOOD PRESSURE
Amoxicillin And Clavulanate Potassium - Amoxicillin: Clavulanate Potassium 500 mg;eq 125 mg base 1 TAB by mouth twice a day FOR 4 DAYS
UTI
Zyrtec - Cetirizine Hydrochloride 5 mg, Tablet by mouth once a day 5 mg, Oral, 1 time daily
ALLERGIES
Synthroid - Levothyroxine Sodium 0.025 mg **see current annual edition, 1.8 description of special situations, levothyroxine sodium 25 mcg, 1 Tablet by mouth once a day 25 mcg, 1 time daily before breakfast
HYPOTHYROIDISM
Cozaar - Losartan Potassium 25 mg, 1 Tablet by mouth once a day 25 mg, 1 time daily
BLOOD PRESSURE
Metformin - Metformin Hydrochloride 500MG; 1 TAB by mouth twice a day
DM
Crestor - Rosuvastatin Calcium 10 mg 10 mg, 1 Tablet by mouth once a day 10 mg, 1 time daily
CHOLESTEROL

14. DME and Supplies:
None of the above

15. Safety Measures:
diabetic precautions, , ambulates with assistance, transfer with assist, activity supervision

16. Nutrition:
diabetic

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Exercises Prescribed

19. Mental & Pyschosocial 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

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 Urinary Tract Infection Site Not Specified, 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 adult female recently discharged home following hospitalization for a urinary tract infection. She was discharged on amoxicillin-clavulanate potassium for a four-day course. Her past medical history is significant for type 2 diabetes mellitus (recently restarted on metformin 500 mg twice daily), hypertension, hyperlipidemia, hypothyroidism, a history of orthostatic hypotension, ulcerative colitis, and major depressive disorder. At the time of start of care, the patient is temporarily residing with a friend, Brenda, who is willing and able to assist with all activities of daily living and instrumental activities of daily living. The patient reports plans to return to her own home within one to two weeks, at which time she will be living alone. On skilled nursing assessment, the patient was alert and oriented to person, place, and time. She reported mild abdominal discomfort but denied shortness of breath. Lung sounds were clear throughout. Appetite was described as fair, and the patient reported a bowel movement on the day of assessment. She continues to demonstrate generalized weakness and currently does not have an assistive device available in the home, although she does own a walker that is not presently with her. The patient reports one fall within the past year, which occurred while staying at her daughter's home approximately six weeks ago. Vital signs were obtained as ordered and reviewed per documentation. All medications were reviewed with the patient and caregiver, including dose, frequency, and potential side effects. Education was provided regarding the importance of completing the antibiotic course, monitoring blood glucose levels following the restart of metformin, maintaining adequate hydration, and implementing strategies to prevent recurrent urinary tract infections. Due to her history of orthostatic hypotension, the patient was instructed on slow and deliberate position changes to reduce fall risk. Both the patient and caregiver were receptive to education but would benefit from continued reinforcement. A physical therapy evaluation identified deficits including bilateral lower-extremity weakness, pain, decreased balance, unsteady gait, difficulty with transfers and negotiating steps, and a history of falls, placing the patient at increased risk for further falls and functional decline. The patient currently requires assistance for mobility, particularly when leaving the home, and often relies on holding onto her caregiver for support. Skilled physical therapy is medically necessary to address strength, balance, functional mobility, transfer safety, gait training, and fall prevention in order to promote a safe return to independent living. The patient is in agreement with the physical therapy plan of care, with <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> planned to begin on 12/15/25. Occupational therapy evaluation was also ordered to further assess safety and independence with self-care tasks, particularly in anticipation of the patient's return to living alone. Skilled nursing services are planned to continue per ordered frequency to monitor recovery from UTI, manage chronic conditions, reinforce medication and disease education, and support a safe transition back to the patient's home environment.
 Date of Order 12/13/2025 Orders Physician Face-to-Face Date: 12/09/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 12/13/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Kenetra Hix
3510 Brenbrook Dr
Randallstown, 0 21133
PHONE: 4107375000 FAX: 899290091 NPI: 1972917979

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 : 12/09/2025

27. Attending Physician's Signature and Date Signed **12/19/2025** 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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and treat, OT eval and treat due to Urinary Tract Infection Site Not Specified 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 Hix, Kenetra

SN Careplans

SN WK1: 1 (12/13/25-12/13/25) ,WK2: 1 (12/14/25-12/20/25) ,WK3: 1 (12/21/25-12/27/25) ,WK4: 1 (12/28/25-01/03/26) ,WK5: 1 (01/04/26-01/10/26)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 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; 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: D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, dizziness/syncope, abdominal pain, M1600 - UTI, limited strength, limited endurance, Pain Interference with ADLs, balance deficit

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver, cough/deep breathing exercises

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, * lifestyle modifications low-residue dietary guidelines alternative medicine options for ulcerative colitis, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: I WANT TO GET OUT AND PARTICIPATE IN ACTIVITIES

GOALS
patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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
* lifestyle modifications
* low-residue dietary guidelines
* alternative medicine options for ulcerative colitis
* 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

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 2 (12/14/25-12/20/25) ,WK3: 1 (12/21/25-12/27/25) ,WK4: 1 (12/28/25-01/03/26) ,WK5: 1 (01/04/26-01/10/26) ,WK6: 1 (01/11/26-01/17/26) ,WK7: 1 (01/18/26-01/24/26) ,WK8: 1 (01/25/26-01/31/26) ,WK9: 1 (02/01/26-02/07/26) ,WK10: 1 (02/08/26-02/10/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, 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: home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., therapeutic modalities: Apply heat or ice to L lower back starting at 5 miniutes, increaing up to a maximum of 20 minutes with necessary barrier and skin assessments q 5 minutes. Pt to start with using heat to see if it relieves pain. If heat is ineffective with try ice as a secondary modality., dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention

TEACH PATIENT/CAREGIVER: * 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

PT Goals

PATIENT-STATED GOAL: I just want to get stronger

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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 - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/13/2025

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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 - 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

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: 6 (12/13/25-12/13/25)

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

PROCEDURES: cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation

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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: To ne able to manage in my own home

GOALS
Shower/Bathe Self - 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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/13/2025