Home Health Certification and Plan of Care

Order ID: 1150/15869

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
11482826250	01/28/2026	From: 01/28/2026 To: 03/28/2026	21860	217058

6. Patient's Name and Address

Sondra Hopkins
6410 BEECHWOOD DR,
COLUMBIA, MD 21046-
443-472-5978

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 05/14/1962 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
J18.9	Pneumonia unspecified organism	01/28/26

13. ICD	Other Pertinent Diagnoses	Date
A40.3	Sepsis due to Streptococcus pneumoniae	01/28/26
A04.72	Enterocolitis d/t Clostridium difficile not spcf as recur (A04.72)	01/28/26
N17.9	Acute kidney failure unspecified	01/28/26
E87.20	Acidosis unspecified	01/28/26
I95.9	Hypotension unspecified	01/28/26
D69.6	Thrombocytopenia unspecified	01/28/26
D64.9	Anemia unspecified	01/28/26
E88.09	Oth disorders of plasma-protein metabolism NEC	01/28/26
E46.	Unspecified protein-calorie malnutrition	01/28/26

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

Vancocin Hydrochloride - Vancomycin Hydrochloride eq 125 mg base 125mg; 1 cap by mouth four times a day puenmonia 10 days
Folic Acid - Folic Acid 1 mg 1 mg; tab by mouth once a day supplement
Mucinex - Guaifenesin 600 mg 600mg; 2 tabs by mouth twice a day cough and congestion
Lactobacillus - Lactinex 1capsule by mouth twice a day probiotic
Multivitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tab by mouth once a day supplement
Benzonatate - Benzonatate 100 mg 100mg ; 1 cap by mouth three times a day as needed for cough

14. DME and Supplies:

walker, commode, incentive spirometer; flutter valve

15. Safety Measures:

ambulates with device, walker precautions, , ambulates with assistance, transfer with assist, supervision at all times, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

bacitra-neomycin-polmyxin

18.A. Functional Limitations

Endurance, Dyspnea With Minimal Exertion, Ambulation

18.B. Activities Permitted

Up As Tolerated, Exercises Prescribed, Walker

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: 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 Pneumonia Unspecified Organism , 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 63-year-old female with no significant prior medical history who recently presented to the emergency department with a two-week history of cough, congestion, and progressively worsening shortness of breath. She was diagnosed with sepsis secondary to Streptococcus pneumoniae pneumonia, complicated by hypoalbuminemia with evidence of third spacing and acute kidney injury (AKI). During hospitalization, she was treated with intravenous antibiotics and remains on vancomycin, which per spouse report was extended by the managing physician for an additional 10 days. Skilled nursing services are ordered with a frequency of 1W1, 2W2, and 1W3, and physical and occupational therapy evaluations have been initiated. Family members provide assistance with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient is alert and oriented 3. A hoarse voice is noted. She denies pain but reports shortness of breath with minimal exertion and a persistent cough that worsens in the evening. Lung auscultation reveals diminished breath sounds bilaterally with expiratory wheezing. The abdomen is distended, and trace bilateral lower extremity edema is present. Skin color appears pale and dusky. The patient appears frail and generally weak. She utilizes a walker in the home for safe ambulation. Skilled nursing reviewed all current medications with the patient and spouse, including dosages, frequency, and pertinent side effects. Education was provided on the use of an incentive spirometer and flutter valve for pulmonary toileting; however, the patient reports inability to tolerate their use due to exacerbation of coughing. Both the patient and caregiver were receptive to education and verbalized understanding. The patient demonstrates significant deconditioning following hospitalization. She presents with bilateral lower extremity weakness (manual muscle testing 3-/5), impaired balance, poor endurance, and an unsteady gait. She requires assistance for transfers and short-distance ambulation and is at increased risk for falls. Additionally, she demonstrates bilateral upper extremity weakness (MMT 3+/5). She experiences shortness of breath with conversation and limited activity tolerance. She requires contact guard assistance for sit-to-stand transfers as well as commode and toilet transfers. She currently requires assistance with bathing and dressing and performs hygiene tasks at the sink due to limited endurance. The patient resides with her husband in a multi-level home with a first-floor setup and ambulates using a rolling walker. Skilled home health physical therapy is medically necessary to address deficits in strength, balance, gait, transfers, endurance, and fall prevention in order to restore safe functional mobility within the home and improve independence with daily activities. Continued skilled nursing is required to monitor cardiopulmonary status, response to antibiotic therapy, edema, skin integrity, and overall recovery from sepsis and pneumonia, as well as to reinforce education and support the patient and caregiver in the plan of care.
 Date of Order 01/28/2026 Orders Physician Face-to-Face Date: 01/25/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management PT-eval & treat OT-eval & treat due to Pneumonia Unspecified Organism 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 Ambati, Madhavi

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 01/28/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Madhavi Ambati
Victory Viaa Shopping Center
Middle River, MD 21108
PHONE: 800-777-7904 FAX: 18554141694 NPI: 1396056297

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 : 01/25/2026

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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SN WK1: 1 (01/28/26-01/31/26) ,WK2: 2 (02/01/26-02/07/26) ,WK3: 2 (02/08/26-02/14/26) ,WK4: 1 (02/15/26-02/21/26) ,WK5: 1 (02/22/26-02/28/26) ,WK6: 1 (03/01/26-03/07/26)

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; 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: , M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, swelling in the arms/legs, dependent edema, coughing, wheezing, lung sounds not clear, limited strength, limited endurance, balance deficit, pallor

PROCEDURES: cough/deep breathing exercises, incentive spirometer

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 medicatio, * 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

PATIENT-STATED GOAL: MY FOCUS IS TO GET MY STRENGTH BACK

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 medicatio

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: 1 (02/01/26-02/07/26) ,WK3: 1 (02/08/26-02/14/26) ,WK4: 1 (02/15/26-02/21/26) ,WK5: 1 (02/22/26-02/28/26) ,WK6: 1 (03/01/26-03/07/26) ,WK7: 1 (03/08/26-03/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: HEP: 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., Medication Review-: Patient verbalized understanding of current prescriptions, dosages, and schedule. No reported issues with adherence, side effects, or confusion at this time. , cough/deep breathing exercises, 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 medicatio, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer -

PT Goals

PATIENT-STATED GOAL: Not to go back to hospital

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 medicatio

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/28/2026

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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 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: 4 (01/28/26-01/31/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: Patient/caregiver recalls related purpose and schedule of medications: Medication review , therapeutic exercises, work simplification/energy conservation, 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 medicatio, Oral Hygiene - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent, Patient will demonstrate improved bilateral upper extremity muscle strength from 3+/5 mmt to 4+/5 mmt to improve ADLs and transfers within 6 wks

OT Goals

PATIENT-STATED GOAL: Patient wants to be herself again and breath 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 medicatio

Oral Hygiene - 06. Independent

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Patient will demonstrate improved bilateral upper extremity muscle strength from 3+/5 mmt to 4+/5 mmt to improve ADLs and transfers within 6 wks

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/28/2026