

Home Health Certification and Plan of Care				Order ID: 1150/16492	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
31558971		02/21/2026		From: 02/21/2026 To: 04/21/2026	
4. Medical Record No.		5. Provider No.			
22615		217058			
6. Patient's Name and Address Dolores Johnson 3502 Grantley Road, BALTIMORE, MD 21215- 410-963-5729			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 01/10/1938			9.Sex Female		
10. Medications: Dose/Frequency/Route (N)ew (C)hanged					
11. ICD Principal Diagnosis			Date		
111.0 Hypertensive heart disease with heart failure			02/21/26		
13. ICD Other Pertinent Diagnoses			Date		
150.22 Chronic systolic (congestive) heart failure			02/21/26		
150.30 Unspecified diastolic (congestive) heart failure			02/21/26		
I27.20 Pulmonary hypertension unspecified			02/21/26		
E78.5 Hyperlipidemia unspecified			02/21/26		
M51.369 Oth intvrt disc degen lum rgn w/o lum bck or lw extrm painOth intvrt disc degen lum rgn w/o lum bck or lw extrm pain			02/21/26		
G89.29 Other chronic pain			02/21/26		
F32.A Depression unspecified			02/21/26		
K21.9 Gastro-esophageal reflux disease without esophagitis			02/21/26		
K59.00 Constipation unspecified			02/21/26		
Z91.81 History of falling			02/21/26		
14. DME and Supplies: walker, cane			15. Safety Measures: ambulates with device, walker precautions, , ambulates with assistance, activity supervision		
16. Nutrition: cardiac diet			17. Allergies: no known allergies		
18.A. Functional Limitations Ambulation, Endurance			18.B. Activities Permitted Cane, Walker, Exercises Prescribed		
19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., 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 family/caregiver will be responsible for managing treatment patient will be responsible for managing treatment		
Homebound status: Due to diagnosis of Hypertensive Heart Disease With Heart Failure, 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 88-year-old female recently discharged from Roland Rehabilitation following hospitalization for a fall that exacerbated pre-existing left lower extremity pain. Her past medical history is significant for chronic heart failure, pulmonary hypertension, hyperlipidemia, hypokalemia, and dorsalgia. Prior to hospitalization, she was independent with ambulation using a single-point cane, limited primarily by chronic left hip pain. She now demonstrates a decline in functional mobility and activities of daily living secondary to worsening pain and generalized weakness. Skilled nursing services are ordered at a frequency of 1 week for 1 visit, 2 weeks for 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh>, and 1 week for 1 visit, with physical and occupational therapy evaluations completed and ongoing services initiated. The patient resides in a two-story home with a first-floor setup currently in place. Her daughter provides assistance with all ADLs, IADLs, and medication management, and a grandson also resides in the home. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient is alert and oriented to person, place, and time. She reports left-sided body pain rated 8/10. She is prescribed tramadol 50 mg every six hours as needed and acetaminophen for pain management; however, she reports taking tramadol only twice daily and not taking acetaminophen as prescribed. She has expressed reluctance to take tramadol at the ordered frequency and plans to discuss pain management options with her primary care provider during an upcoming virtual visit, including the possibility of orthopedic consultation. The patient declined the use of ice therapy for left hip pain. She denies shortness of breath at the time of the visit. Lung sounds are clear throughout. Bilateral lower extremity edema is noted at +2. She ambulates with a rolling walker for safety. Physical therapy evaluation reveals significant left lower extremity weakness, with manual muscle testing approximately 2-/5. The patient requires contact guard assistance for transfers and short-distance ambulation with a rolling walker and demonstrates difficulty effectively bearing weight through the left lower extremity due to pain. She presents with impaired strength, decreased balance, and reduced endurance, contributing to increased fall risk and decreased independence compared to her prior level of function. Skilled physical therapy is medically necessary to address lower extremity strengthening, balance retraining, gait training, transfer training, and safety awareness in order to restore functional mobility and reduce fall risk. Occupational therapy evaluation indicates further decline in ADL performance related to pain and mobility limitations. The patient requires assistance with self-care tasks and has difficulty with bed mobility, at times sleeping in a chair due to pain. Recommendations were made for the use of a lounge chair and placement of additional pillows under the lower extremities to assist with edema management. Occupational therapy services are planned at a frequency of once weekly for six weeks to focus on ADL retraining, functional mobility training, therapeutic exercise, home exercise program development, and safety training. Skilled nursing reviewed all medications, including dose, frequency, and potential side effects, and reinforced education regarding effective pain management strategies. Education was also provided regarding adherence to prescribed medications and monitoring for symptom changes related to heart failure and pulmonary status. The patient and caregiver verbalized understanding. The interdisciplinary plan of care focuses on pain control optimization, edema management, strengthening, fall prevention, and gradual return toward prior functional status while maintaining safety within the home environment. Date of Order 02/21/2026 Orders Physician Face-to-Face Date: 01/22/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat due to Hypertensive Heart Disease With Heart Failure 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 Cooper, Robert					
SN Careplans			SN Goals		
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 02/21/2026				25. Date HHA Received Signed POT	
24. Physician's Name and Address Robert Cooper 6503 Park Heights Ave Baltimore, MD 21215 PHONE: 4103582397 FAX: 14103582399 NPI: 1235159898			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 : 01/22/2026		
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. PAGE 1 of 4		

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SN WK1: 1 (02/21/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26) ,WK3: 2 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK5: 1 (03/15/26-03/21/26) 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: 3. Multiple hospitalizations (2 or more) in the past 6 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; 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:POLST (Physician Orders for Life-Sustaining Treatment) PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, limited range of motion, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit PROCEDURES: cough/deep breathing exercises, home exercise program 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals			PATIENT-STATED GOAL: I DONT WANT TO TAKE TOO MUCH TRAMADOL FOR THE PAIN GOALS 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 * 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 * prevention exacerbation of anxiety condition including coping patterns * improved concentration * strategies to reduce anxiety * identification of anxiety precipitants, conflicts, and threats * 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: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK5: 1 (03/15/26-03/21/26) ,WK6: 1 (03/22/26-03/28/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, 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			PT Goals PATIENT-STATED GOAL: To be able to walk without pain GOALS 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			
Signature of Physician:			Date			
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Optional Name/Signature of Nurse/Therapist:			Date			
Electronically Signed by Messick, Charles RN			02/21/2026			

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PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, gait training/stair training, transfers training 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 diversional activities, related medication(s) purpose, schedule, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 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, 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Medication Review		Sit to Stand - 05. Setup or clean-up assistance Chair to Bed to Chair - 05. Setup or clean-up assistance Toilet Transfer - 05. Setup or clean-up assistance 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 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 Car Transfer - 05. Setup or clean-up assistance Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance Medication Review		
OT Careplans		OT Goals		
OT WK2: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK5: 1 (03/15/26-03/21/26) ,WK6: 1 (03/22/26-03/28/26) ,WK7: 1 (03/29/26-03/31/26) 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, equipment training, work simplification/energy conservation, transfers training, transfers training, assist with meal preparation 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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 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, 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent		PATIENT-STATED GOAL: To not be in pain 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 Sit to Stand - 05. Setup or clean-up assistance Chair to Bed to Chair - 05. Setup or clean-up assistance Toilet Transfer - 05. Setup or clean-up assistance 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 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 Car Transfer - 05. Setup or clean-up assistance Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance Oral Hygiene - 06. Independent Toileting Hygiene - 05. Setup or clean-up assistance Shower/Bathe Self - 03. Partial/moderate assistance Upper Body Dressing - 05. Setup or clean-up assistance Lower Body Dressing - 05. Setup or clean-up assistance Don/Doff Footwear - 05. Setup or clean-up assistance Eating - 06. Independent		
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