Home Health Certification and Plan of Care

Order ID: 1150/16847

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1YF3R37CH00	03/05/2026	From: 03/05/2026 To: 05/03/2026	23140	217058

6. Patient's Name and Address

Magaline Jones
5107 Old Court Rd Apt 119,
RANDALLSTOWN, MD 21133-
404-934-0556

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 03/08/1940 | **9.Sex** Female

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

Trazodone - Trazodone Hydrochloride 0 50 mg / 1 Tablet by mouth in the evening As needed for sleep
QUETIAPINE FUMARATE 0 25 mg / 1/2 Tablet by mouth every 6 hours Take 0.5 tablets as
needed for Other (agitation). Commonly known as: SEROquel
Naproxen - Naproxen 500 mg 500 mg / 1 Tablet by mouth twice a day with meals.
Commonly known as: NAPROSYN

11. ICD	Principal Diagnosis	Date
F01.518	Vascular dementia unsp severity with other beh disturb	03/05/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	03/05/26
I73.9	Peripheral vascular disease unspecified	03/05/26
J44.9	Chronic obstructive pulmonary disease unspecified	03/05/26
G62.9	Polyneuropathy unspecified	03/05/26
E78.5	Hyperlipidemia unspecified	03/05/26
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	03/05/26
G89.29	Other chronic pain	03/05/26
K21.9	Gastro-esophageal reflux disease without esophagitis	03/05/26
E55.9	Vitamin D deficiency unspecified	03/05/26
E44.0	Moderate protein-calorie malnutrition	03/05/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	03/05/26
Z87.891	Personal history of nicotine dependence	03/05/26

14. DME and Supplies:

4 wheeled walker

15. Safety Measures:

bathroom safety, ambulates with device, hip precautions, knee precautions, medication safety, fall precautions, walker precautions, activity supervision

16. Nutrition:

regular

17. Allergies:

hydrochlorothiazide

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: 4. Constantly, SOCIAL ISOLATION: 8. Patient unable to respond, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions!6. Delusional, hallucinatory, or paranoid behavior, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: 8. Unknown, MOBILITY: 8. Unknown

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Vascular dementia, unspecified severity, with other behavioral disturbance, 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 86-year-old female with a past medical history significant for hypertension and dementia, recently admitted to home health services due to worsening dementia symptoms. According to her son, the patient has been wandering outside her apartment and experiencing visual hallucinations. During the nursing assessment, the patient was alert but oriented only to her name and required prompts from mail and a note on the wall to recall and spell her last name and identify her son. She was observed speaking out of turn and questioning the presence of a woman in the hallway, although no one was present. The patient is ambulatory with a rollator but demonstrates a limp on the right side and reports pain in the right hip and left knee, as well as in her hands and knees. She denies shortness of breath, dizziness, chest pain, or lightheadedness. She is unable to recall her last bowel movement and is unaware of any urinary incontinence. Physical assessment revealed lungs clear to auscultation, audible bowel sounds, dry and intact skin without signs of breakdown, and no complaints of nausea or vomiting. The patient is cooperative but frequently becomes distracted during conversation. Physical therapy evaluation revealed significant bilateral lower extremity weakness (2-/5 MMT), poor balance, decreased endurance, and the need for contact guard assistance with transfers and short-distance ambulation using a rollator. She has also experienced recent falls when attempting to pick objects up from the floor. Additionally, she presents with decreased range of motion in the right shoulder and increased dependence for activities of daily living and functional mobility. Occupational therapy recommendations include the use of a bedside commode and shower chair to assist with transfers and improve safety, as the patient currently requires daily assistance with ADLs. Skilled physical and occupational therapy services are recommended to improve strength, balance, safety, and functional independence.<o:p></o:p> <o:p> </o:p> Bottom of Form<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 03/05/2026
 Order<o:p></o:p> Physician Face-to-Face Date: 02/27/2026
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Vascular dementia, unspecified severity, with other behavioral disturbance
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
 1 - SOC -SN Notes: <o:p></o:p> PT Eval Notes:<o:p></o:p> OT Eval Notes:<o:p></o:p> Physician:<span style="font-size: 10.5pt; background-image: initial; background-position: initial; background-size: initial; background-repeat: initial; background-attachment: initial; background-origin: initial; background-clip: initial;"> Eseonu Ewoh, Nkechinyerem

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/05/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Nkechinyerem Eseonu Ewoh
7070 Samuel Morse Dr
Columbia, MD 21246
PHONE: FAX: NPI: 1114247541

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 : 02/27/2026

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 (03/05/26-03/07/26) ,WK2: 2 (03/08/26-03/14/26) ,WK3: 2 (03/15/26-03/21/26) ,WK4: 2 (03/22/26-03/28/26)

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: 5. Decline in mental, emotional, or behavioral status in the past 3 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; 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: M1700 - Cognition, M1745 - Behavioral Issues, M2020 - Oral Med Management, meal preparation, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, M1610 - Urinary Incontinence, limited endurance, limited strength, limited range of motion, balance deficit, B1000 - Vision Deficit

PROCEDURES: cough/deep breathing exercises, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, 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 keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin 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, * 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 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

PATIENT-STATED GOAL: Unable to verbalize any goals

GOALS
patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* 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
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

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

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
03/05/2026

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PT WK1: 1 (03/05/26-03/07/26) ,WK2: 1 (03/08/26-03/14/26) ,WK3: 1 (03/15/26-03/21/26) ,WK4: 1 (03/22/26-03/28/26) ,WK5: 1 (03/29/26-04/04/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, GG0170I1 - Walk 10 Feet, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, 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: - medications reviewed with patient/caregiver, 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 - 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, 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

PATIENT-STATED GOAL: To be able to walk without 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

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 WK1: 1 (03/05/26-03/07/26) ,WK2: 2 (03/08/26-03/14/26) ,WK3: 2 (03/15/26-03/21/26) ,WK4: 1 (03/22/26-03/28/26)

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: 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, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 05. Setup or clean-up assistance, Increase endurance to F+

OT Goals

PATIENT-STATED GOAL: To be able to walk better and do more for myself

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

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

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

Increase endurance to F+

Shower/Bathe Self - 02. Substantial/maximal assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 05. Setup or clean-up assistance

HHA Careplans

HHA WK1: 10 (03/05/26-03/07/26)

PROCEDURES: assist with bathing, assist with toilet transferring, assist with toileting hygiene, assist with transferring, assist with mobility, assist with feeding/eating, assist with infection control, assist with fall prevention, assist with assistive devices prn, assist with O2 safety, assist with lower body dressing, assist with upper body dressing

HHA Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
03/05/2026