Home Health Certification and Plan of Care

Order ID: 1150/15762

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2A72J21AW23	01/21/2026	From: 01/21/2026 To: 03/21/2026	21570	217058

6. Patient's Name and Address

Margaret Galles
8243 Lethbridge Rd,
MILLERSVILLE, MD 21108-
410-987-4350

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 05/18/1934 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I48.91	Unspecified atrial fibrillation	01/21/26

13. ICD	Other Pertinent Diagnoses	Date
G30.0	Alzheimer's disease with early onset	01/21/26
F02.80	Dem in oth dis classd elswhrunsp sevw/o beh/psych/mood/anx	01/21/26
I11.9	Hypertensive heart disease without heart failure	01/21/26
I21.A1	Myocardial infarction type 2	01/21/26
I35.8	Other nonrheumatic aortic valve disorders	01/21/26
I05.8	Other rheumatic mitral valve diseases	01/21/26
E78.5	Hyperlipidemia unspecified	01/21/26
I27.20	Pulmonary hypertension unspecified	01/21/26
M81.0	Age-related osteoporosis w/o current pathological fracture	01/21/26
Z87.01	Personal history of pneumonia (recurrent)	01/21/26
Z86.19	Personal history of other infectious and parasitic diseases	01/21/26
Z79.01	Long term (current) use of anticoagulants	01/21/26

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

Eliquis - Apixaban 2.5 mg ; 1tablet by mouth twice a day blood thinner a-fib
Atorvastatin - Atorvastatin Calcium 10mg; tab by mouth at bedtime at bedtime for HLD
Metoprolol Tartrate - Metoprolol Tartrate 50 mg 50mg; 1 tab by mouth twice a day a fib
Senna - Senna 8.6 mg; 1 tab by mouth once a day bowel regimen
Rolaids - Rolaids 675mg; 1 tab by mouth once a day bone support
Vitamin D - Ergocalciferol 1000 IU ; 1 TAB by mouth in the evening BONE SUPPORT
Centrum Silver - Ascorbic Acid: Biotin: Cyanocobalamin: Ergocalciferol: Folic Acid: Niacinamide: Pantothenic Acid: Phytonadione: Pyridoxine: Ribo 1 TAB by mouth once a day SUPPLEMENT

14. DME and Supplies:

wheelchair, urinary/catheter supplies, bath bench, walker, grab bars, commode, wound care supplies, cane

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:

codeine morphine benzodiazepines

18.A. Functional Limitations

Ambulation, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted

Wheelchair, Up As Tolerated, Cane, Walker, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 0. Never, 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, HISTORY OF DEPRESSION: No

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

Homebound status: Due to diagnosis of Alzheimer'S Disease With Early Onset, 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 91-year-old female with a complex medical history including hypertension, dyslipidemia, atrial fibrillation with rapid ventricular response, early dementia, osteopenia, valvular heart disease (including aortic valve sclerosis, mitral valve disorder, left ventricular hypertrophy, and mild pulmonary hypertension), seasonal allergic rhinitis, and a history of hypoxic respiratory failure. Past surgical history includes tubal ligation in 1974 and diagnostic colonoscopies in 2009 and 2011. The patient was recently admitted to the hospital on 01/06/2026 after being found at home with significantly elevated blood pressure and heart rate. Hospital evaluation revealed atrial fibrillation with rapid ventricular response, hypoxic respiratory failure, and infectious findings positive for human metapneumovirus, with imaging and clinical presentation consistent with multifocal pneumonitis and acute bronchitis, with possible early community-acquired pneumonia. The patient experienced significant deconditioning during hospitalization. The patient resides with her spouse in a multilevel single-family home with two steps to enter and five to six steps to access the main living level. Family members, including the spouse and daughter, provide assistance with all activities of daily living and instrumental activities of daily living. Skilled nursing services have been initiated at a frequency of 1 visit per week for 12 weeks, followed by 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> per week for 1 week, then 1 visit per week for 6 weeks, with physical therapy and occupational therapy evaluations ordered. On assessment, the patient was alert and oriented to person and place but required reorientation to time, consistent with baseline cognitive impairment related to early dementia. She denied pain and shortness of breath at the time of assessment. Respiratory examination revealed lungs clear to auscultation throughout. The patient reported a good appetite and stated her last bowel movement occurred the previous evening. No peripheral edema was noted. Skin assessment revealed a stage II pressure ulcer on the right side. The patient ambulates using a rolling walker with supervision and demonstrates a shuffling gait with small stride length, resting tremors, reduced plantar sensation bilaterally, and impaired balance. She is able to follow two-step directions. The patient requires supervision for ambulation and assistance with bathing and basic activities of daily living. A history of cataract removal was noted. Family reports that the patient experienced a prior mini-stroke in October 2024, resulting in worsening memory deficits. The patient has been using a walker since April 2025. Family also reported a recent tooth infection that temporarily reduced oral intake; the patient is currently tolerating soft, ground foods with improved nutritional intake. The patient has a history of constipation related to medication use, which has recently improved. Skilled nursing reviewed all current medications with the patient and caregivers, including indications, dosages, frequency, and pertinent side effects. Education was provided regarding signs and symptoms of bleeding related to anticoagulation therapy for atrial fibrillation. Instruction was also given on pressure ulcer care, offloading techniques, repositioning, and skin protection measures to prevent further compromise of skin integrity. The patient's daughter and spouse verbalized understanding of all education provided. Physical therapy services are medically necessary to assess gait mechanics, improve lower extremity strength

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 01/21/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Bahador Momeni
8601 Veterans Hwy
Millersville, MD 21108
PHONE: 4105538090 FAX: 14107292404 NPI: 1164428264

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 : 01/16/2026

27. Attending Physician's Signature and Date Signed **01/30/2026**: 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 range of motion, enhance dynamic balance and coordination, increase activity tolerance, promote safety awareness, and reduce fall risk. Interventions will include gait training, therapeutic exercises, balance training, environmental hazard awareness, compensatory and adaptive strategies, and anticipatory reaction training to improve functional mobility and independence. Occupational therapy services are indicated to address deficits in activities of daily living, safety, and caregiver education. Without skilled therapeutic intervention, the patient remains at high risk for falls, further functional decline, immobility, and increased caregiver burden. The plan of care focuses on maximizing safety, maintaining functional abilities, supporting caregiver training, and facilitating a safe transition to the next appropriate level of care while enhancing the patient's quality of life.
 Date of Order 01/21/2026 Orders Physician Face-to-Face Date: 01/16/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Alzheimer'S Disease With Early Onset Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home, other
 1 - SOC - SN Notes: soc OT Eval Notes: PT Eval Notes:
 Physician Momeni, Bahador

SN Careplans

SN WK1: 1 (01/21/26-01/24/26) ,WK2: 2 (01/25/26-01/31/26) ,WK3: 2 (02/01/26-02/07/26) ,WK4: 1 (02/08/26-02/14/26) ,WK5: 1 (02/15/26-02/21/26) ,WK6: 1 (02/22/26-02/28/26) ,WK7: 1 (03/01/26-03/07/26) ,WK8: 1 (03/08/26-03/14/26) ,WK9: 1 (03/15/26-03/20/26)

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, 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

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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M1745 - Behavioral Issues, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, M1610 - Urinary Incontinence, muscle weakness, limited range of motion, limited strength, limited endurance, weak hand grips, balance deficit, bruising/discoloration, #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Other - RIGHT BUTTOCK - SCANT AMOUNT OF SEROSANGUINEOUS DRAINAGE NOTED

PROCEDURES: physician-ordered wound care: #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Other - RIGHT BUTTOCK - SCANT AMOUNT OF SEROSANGUINEOUS DRAINAGE NOTED: SN/CG TO CLEANSE THE RIGHT BUTTOCK (SACRAL REGION)STAGE 2 PRESSURE ULCER , PAT DRY, APPLY DUODERM HYDROACTIVE. EVERY THREE DAYS AND PRN FOR SOILED DRESSING. CG IS INDEPENDENT WITH WOUND CARE., physician-ordered wound care: #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink

SN Goals

PATIENT-STATED GOAL: WE WANT HER TO GET BACK TO HER BASELINE OF WALKING

GOALS
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/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 medicatio

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

patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/21/2026

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wound bed. - Other - RIGHT BUTTOCK - SCANT AMOUNT OF SEROSANGUINEOUS DRAINAGE NOTED: SN/CG TO CLEANSE THE RIGHT BUTTOCK (sACRAL rEGION)STAGE 2 PRESSURE ULCER , PAT DRY, APPLY DUODERM HYDROACTIVE. EVERY THREE DAYS AND PRN FOR SOILED DRESSING. CG IS INDEPENDENT WITH WOUND CARE.

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 medicatio, * 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (01/21/26-01/24/26) ,WK2: 2 (01/25/26-01/31/26) ,WK3: 2 (02/01/26-02/07/26) ,WK4: 1 (02/08/26-02/14/26) ,WK5: 1 (02/15/26-02/21/26) ,WK6: 1 (02/22/26-02/28/26) ,WK7: 1 (03/01/26-03/07/26) ,WK8: 1 (03/08/26-03/14/26) ,WK9: 1 (03/15/26-03/20/26)

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: 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 medicatio, * 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 relaxatio, 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 - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Car Transfer - 06. Independent

PT Goals

PATIENT-STATED GOAL: patient wants to be able to return to walking with a small base quad cane as she did prior to hosp.

GOALS
Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 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 medicatio

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 relaxatio

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 - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Car Transfer - 06. Independent

OT Careplans

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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: Home exercise program , Therapeutic exercise , Balance training , Medication review , standing tolerance , cough/deep breathing exercises, equipment training, work simplification/energy conservation, 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 -

OT Goals

PATIENT-STATED GOAL: to improve general health and get to better functioning

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/21/2026

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06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, 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, Upper Body Dressing - 06. Independent

* recalls related medicatio

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 4 of 4
Optional Name/Signature of Nurse/Therapist:	Date
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