Home Health Certification and Plan of Care

Order ID: 1150/17501

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
85132721	03/25/2026	From: 03/25/2026 To: 05/23/2026	24046	217058

6. Patient's Name and Address
Doreen Martin
120 Lincoln Avenue,
GLEN BURNIE, MD 21061-
410-903-3109

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 08/15/1964 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M54.41	Lumbago with sciatica right side	03/25/26

13. ICD	Other Pertinent Diagnoses	Date
I11.9	Hypertensive heart disease without heart failure	03/25/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	03/25/26
S91.012D	Laceration without foreign body left ankle subs encntr	03/25/26
E78.00	Pure hypercholesterolemia unspecified	03/25/26
M54.16	Radiculopathy lumbar region	03/25/26
F32.A	Depression unspecified	03/25/26
M79.7	Fibromyalgia	03/25/26
K21.9	Gastro-esophageal reflux disease without esophagitis	03/25/26
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	03/25/26
F41.1	Generalized anxiety disorder	03/25/26
R32.	Unspecified urinary incontinence	03/25/26
E66.01	Morbid (severe) obesity due to excess calories	03/25/26
Z68.41	Body mass index [BMI] 40.0-44.9 adult	03/25/26
Z87.891	Personal history of nicotine dependence	03/25/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	03/25/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	03/25/26
Z79.1	Long term (current) use of non-steroidal non-inflam (NSAID)	03/25/26
Z96.651	Presence of right artificial knee joint	03/25/26
Z91.81	History of falling	03/25/26

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

MELOXICAM 15 mg by mouth once a day as needed for Pain. Commonly known as: MOBIC
GLIPIZIDE 5 mg / 1 Tablet by mouth in the morning Take 10 mg by mouth daily before breakfast. Commonly known as: GLUCOTROL
GABAPENTIN 300 mg / 1 Capsule by mouth three times a day Take 900 Commonly known as: NEURONTIN
Cefpodoxime Proxetil - Cefpodoxime Proxetil eq 200 mg base / 1 Tablet by mouth twice a day daily for 5 days. Commonly known as: VANTIN
Losartan Potassium - Losartan Potassium 50 mg / 1 Tablet by mouth once a day Commonly known as: COZAAR
Atorvastatin - Atorvastatin Calcium 40 mg / 1 Tablet by mouth once a day Commonly known as: LIPITOR
Bupropion Hydrochloride - Bupropion Hydrochloride 150 mg by mouth once a day Commonly known as: WELLBUTRIN XL
Coenzyme Q10 Caps 100 MG by mouth
Duloxetine Hydrochloride - Duloxetine Hydrochloride 30 mg by mouth in the morning 30 mg in am 60 mg in pm Commonly known as: CYMBALTA
Metformin - Metformin Hydrochloride 1000 mg / 1 Tablet by mouth twice a day with meals. Indications: Type 2 Diabetes For: Type 2 Diabetes Commonly known as: GLUCOPHAGE
Vitamin D - Ergocalciferol 50 MCG (2000 UT) Caps / Take 2,000 units by mouth once a day

14. DME and Supplies:
rolling walker, hand held shower, bath bench, cane

15. Safety Measures:
transfer with assist, hand rails, , diabetic precautions, , avoid temperature extremes, ambulates with device, , emergency phone number prominently displayed, ambulates with assistance, walker precautions, smoke detectors , , bathroom safety, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
erythromycin indomethacin lisinopril chocolate

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Cane, Up As Tolerated, Walker, Exercises Prescribed, Transfer bed/Chair

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

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

Homebound status: Due to diagnosis of Lumbago with sciatica right side, 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 61-year-old female who was admitted to BWMC from 03/22 to 03/23 following a syncopal episode that occurred after church. She has since returned home with continuous assistance from family members. The patient resides in a split-foyer home with her spouse, who is currently available full-time but plans to return to work. The home environment includes two steps with a railing at the entrance and an additional seven steps to access the main living level where the patient primarily remains. Prior to hospitalization, the patient was ambulatory with a cane; however, she now requires a front-wheeled walker for mobility. She reports one fall within the past two months. A physical therapy start-of-care (SOC) assessment was completed, including consent acquisition, medication reconciliation, and a comprehensive home safety evaluation. The patient presents with bilateral knee and low back pain, decreased strength in the lower extremities, impaired balance, reduced functional mobility, and difficulty with transfers, gait, and stair negotiation. She demonstrates an unsteady gait, decreased safety awareness, and an elevated risk for falls. Despite these impairments, pain is currently well controlled with prescribed medications. On examination, the patient requires standby assistance (SBA) for transfers and ambulation using a front-wheeled walker. Gait assessment revealed the need for cueing to maintain proper positioning within the walker, increase bilateral step height and length, and ensure overall safety. Standardized assessments, including the Tinetti and Timed Up and Go (TUG), were performed to evaluate fall risk and mobility status. The patient also has a non-removable dressing on the left ankle with two sutures in place, scheduled for removal by her primary care provider on 03/27/26. She was educated on signs and symptoms of infection, including fever, chills, redness, swelling, increased pain, bleeding, or discharge, as well as when to seek medical attention. Skilled physical therapy interventions focused on transfer training, gait training, and fall prevention strategies. The patient was instructed in safe transfer techniques, including proper hand and foot placement, forward weight shifting, and controlled descent when sitting. She was also trained in safe ambulation on level surfaces using a walker and was advised to use the assistive device at all times. Education was provided on the importance of daily ambulation to promote circulation and prevent complications related to inactivity. A structured walking program was initiated, starting with short walks every 1-2 hours and gradually progressing to longer durations as tolerated. Pain management

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/25/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Uchemadu Nwaononiwu
7670 Quarterfield Road
Glen Burnie, MD 21061
PHONE: FAX: NPI: 1770710451

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 : 03/23/2026

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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education was reinforced, including taking medications at the onset of pain, awareness of potential side effects such as dizziness and constipation, and the recommendation to take pain medication approximately one hour prior to therapy sessions for optimal participation. Additional interventions included instruction on the application of ice to bilateral knees for 20 minutes with appropriate skin protection and monitoring. Comprehensive education from the patient handbook was provided, including fall risk factors, home safety modifications, and preventative strategies to reduce fall risk. The patient demonstrated understanding through teach-back. A physical therapy plan of care was developed collaboratively with the patient and caregiver, with both in agreement. The patient is scheduled to receive home physical therapy services at a frequency of 1 visit in the first week, followed by 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-visits">visits</mh> per week for 3 weeks, then 1 visit per week for 3 weeks. Due to her current functional limitations, need for assistive device, and high fall risk, the patient is considered homebound, requiring assistance to safely leave the home. Skilled physical therapy services are medically necessary to address her deficits, improve functional independence, and prevent further decline.
 Date of Order 03/25/2026 Orders Physician Face-to-Face Date: 03/23/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT due to Lumbago with sciatica right side 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 - PT Notes: soc
 Physician Nwaononiwu, Uchemadu

SN Careplans

SN Goals

PT Careplans

PT WK1: 1 (03/25/26-03/28/26) ,WK2: 2 (03/29/26-04/04/26) ,WK3: 2 (04/05/26-04/11/26) ,WK4: 2 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26) ,WK6: 1 (04/26/26-05/02/26) ,WK7: 1 (05/03/26-05/09/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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

PT Goals

PATIENT-STATED GOAL: I want to be able to walk with my cane again.

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Shower/Bathe Self - 05. Setup or clean-up assistance

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
* 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
* 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
* 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

caregiver administers and/or packages medications appropriately

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/25/2026

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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: GG0130B1 - Oral Hygiene, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0170E1 - Chair to Bed to Chair, D0160 - Depression, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, M1033 - Exhaustion, muscle weakness, Pain Effect on Sleep, Pain Interference with ADLs, obesity

PROCEDURES: cough/deep breathing exercises, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. 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 ice to bilateral knees x 20 minutes with necessary barrier and skin assessments q 5 minutes., work simplification/energy conservation, 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., dynamic standing balance exercises, gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention

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, * 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, caregiver administers and/or packages medications appropriately, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching 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

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

Walk 10 ft on Uneven Surface - 04. Supervision or touching 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 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/25/2026