Home Health Certification and Plan of Care

Order ID: 1150/17887

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6KJ3UC5PN06	04/07/2026	From: 04/07/2026 To: 06/05/2026	24518	217058

6. Patient's Name and Address
Marilyn Allen
7921 Oakwood Rd,
GLEN BURNIE, MD 21061-
443-763-1254

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 04/06/1953 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
G93.49	Other encephalopathy	04/07/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	04/07/26
F03.93	Unsp dementia unspecified severity with mood disturb	04/07/26
F32.A	Depression unspecified	04/07/26
G89.4	Chronic pain syndrome	04/07/26
N13.2	Hydronephrosis with renal and ureteral calculous obstruction	04/07/26
N13.9	Obstructive and reflux uropathy unspecified	04/07/26
Z79.01	Long term (current) use of anticoagulants	04/07/26
Z86.19	Personal history of other infectious and parasitic diseases	04/07/26

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

ACETAMINOPHEN 325 MG tablet by mouth every 4 hours as needed for Mild Pain.
Dicyclomine HCL 1 capsule 10mg by mouth as necessary Give 1 capsule by mouth every 6 hours as needed for abdominal pain or cramping
MULTIVITAMIN 1 tablet by mouth one time a day for Supplement
MIRALAX 1 packet by mouth as necessary for Constipation prevention
Meclizine Hydrochloride - Meclizine Hydrochloride 25 mg 1 tablet by mouth twice a day Give 1 tablet by mouth every 12 hours as needed for dizziness
Trazodone Hydrochloride - Trazodone Hydrochloride 50 mg 0.5 tablet by mouth at bedtime Give 0.5 tablet by mouth every 24 hours as needed for depression QHS
Sertraline Hcl - Sertraline Hydrochloride 50 mg by mouth once a day Give 1 tablet by mouth one time a day for depression

14. DME and Supplies:
wheelchair, walker, rolling walker, hoyer lift, hospital bed, commode, 4 wheeled walker

15. Safety Measures:
wheelchair precautions, walker precautions, transfer with assist, supervision at all times, standard precautions, smoke detectors , restricted ROM, medication safety, medical alert/lifeline, knee precautions, fall precautions, bedrails up while in bed, bathroom safety, aspiration precautions, activity supervision

16. Nutrition:
2gm sodium, , , , , ,

17. Allergies:
broccoli

18.A. Functional Limitations
Dyspnea With Minimal Exertion, Ambulation, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted
Walker, Wheelchair, Transfer bed/Chair, Up As Tolerated

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: 2. Sometimes, 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: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Other encephalopathy, 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 73-year-old female with a significant medical history including kidney stones requiring ureteral stent placement by urology to prevent urinary backflow, recent hospitalization for sepsis secondary to urinary tract infection, arthritis, morbid obesity (approximately 326 lbs), chronic pain, and functional decline. The patient was hospitalized for approximately one and a half weeks about one month ago, followed by a subsequent stay in a nursing facility for an additional one and a half weeks before returning home. She was last seen by her primary care provider last Thursday and has scheduled follow-up appointments for stent removal on April 17, 2026, and a urology evaluation with ultrasound on May 29, 2026. Currently, the patient is bedbound, non-ambulatory, and fully dependent for all activities of daily living and mobility. She reports that she has been unable to ambulate for approximately two years; previously, she was able to independently transfer from bed to bedside commode and wheelchair. However, following her recent hospitalization and rehabilitation stay, she has experienced further functional decline and is now unable to stand, transfer, or ambulate, requiring total assistance including use of a Hoyer lift for transfers. The patient resides in a single-level home with her daughter and son-in-law, who provide continuous caregiving support. On assessment, the patient reports bilateral knee pain related to arthritis and right shoulder pain consistent with a history of rotator cuff injury. Physical findings include decreased strength in bilateral lower extremities, impaired bed mobility requiring full assistance, decreased seated balance at the edge of bed, and increased risk for falls and further functional decline. The patient also has a history of skin breakdown that developed during her recent hospitalization and rehabilitation stay, which has since resolved with residual scarring noted. The patient is considered homebound due to her bedbound status, inability to ambulate, and need for continuous caregiver assistance. She is identified as a high fall and safety risk. The patient's daughter has expressed interest in obtaining home health aide services to assist with care needs. Skilled therapy services are indicated at this time. Physical therapy is recommended to address deficits in strength, balance, transfers, and safety awareness with the goal of improving functional mobility and preventing further decline. Without skilled intervention, the patient remains at high risk for falls, deconditioning, and loss of independence. The planned physical therapy frequency is 1 visit per week for 1 week, followed by 2 visits per week for 1 week (Monday/Wednesday), then 1 visit per week for 6 weeks (Wednesday). Additionally, occupational therapy services are indicated to address decreased functional activity tolerance, impaired bed mobility, and generalized muscle weakness, with the goal of maximizing independence and preventing further deconditioning. The patient and primary caregivers are in agreement with the established plan of care.
 Date of Order 04/07/2026 Orders Physician Face-to-Face Date: 04/02/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT/OT and Nursing due to Other encephalopathy 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 Bolinger, Hannah

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 04/07/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Hannah Bolinger
7876 W Riverside Dr
Pasadena, MD 21122
PHONE: 4102550102 FAX: 14102550103 NPI: 1417460718

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 : 04/02/2026

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 (04/07/26-04/11/26) ,WK2: 1 (04/12/26-04/18/26) ,WK3: 1 (04/19/26-04/25/26) ,WK4: 1 (04/26/26-05/02/26) ,WK5: 1 (05/03/26-05/09/26) ,WK6: 1 (05/10/26-05/16/26)

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 > 10

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 2. Unintentional weight loss of a total of 10 pounds or more 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

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; 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 ; 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.

N/A
Advance Directive:YES

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M1720 - Anxiety, M1745 - Behavioral Issues, D0160 - Depression, M2102d - Caregiver Performs Treatment, A1250 - Lack of Necessary Transportation, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M2020 - Oral Med Management, D0700 - Social Isolation, M1400 - Dyspnea, M1033 - Unintentional Weight Loss, abnormal blood pressure, weak pulses in feet, cramping calves/thighs/hips, abnormal electrolyte panel, regurgitation of food, M1620 - Bowel Incontinence, heartburn/indigestion, M1610 - Urinary Incontinence, poor muscle tone, muscle weakness, swelling of affected area, limited endurance, limited range of motion, limited strength, lethargy, Pain Interference with ADLs, daytime fatigue, Pain Interference with Therapy activities, Pain Effect on Sleep, B1000 - Vision Deficit, sensitivity to sounds & light, headache, withdrawal from conversations, balance deficit, involuntary movement of extremity, obesity, loss of appetite, tooth pain/decay/sensitivity, itchy skin, discolored patches of skin, swell/redness surround. skin, red/tender pressure points

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, bladder training, coordinate/arrange for adequate patient supervision, 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 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, * 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, * strategies to increase caloric intake, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises

PATIENT-STATED GOAL: Get the patient up out of bed

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
* 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
* 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
* strategies to increase caloric intake
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* 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
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

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

Signature of Physician:

Date

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

Date
04/07/2026

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skin care, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, * strategies to increase socialization, related medication(s) purpose, schedule, patient's transportation needs are met, 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 WK1: 1 (04/07/26-04/11/26) ,WK2: 2 (04/12/26-04/18/26) ,WK4: 1 (04/26/26-05/02/26) ,WK6: 1 (05/10/26-05/16/26) ,WK8: 1 (05/24/26-05/30/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea, GG0170F1 - Toilet Transfer, GG0170A1 - Roll left & Right, GG0170B1 - Sit to Lying, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments: Administration of HEP, wheelchair 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, Roll left & Right - 06. Independent, Sit to Lying - 06. Independent, Toilet Transfer - 01. Dependent, Wheel 50 ft w 2 Turns - 01. Dependent, Wheel 150 feet - 01. Dependent

PT Goals

PATIENT-STATED GOAL: To be able to get up and to be able to transfer

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

Roll left & Right - 06. Independent

Sit to Lying - 06. Independent

Toilet Transfer - 01. Dependent

Wheel 50 ft w 2 Turns - 01. Dependent

Wheel 150 feet - 01. Dependent

OT Careplans

OT WK1: 1 (04/07/26-04/11/26) ,WK2: 1 (04/12/26-04/18/26) ,WK3: 1 (04/19/26-04/25/26) ,WK5: 1 (05/03/26-05/09/26) ,WK7: 1 (05/17/26-05/23/26) ,WK9: 1 (05/31/26-06/03/26)

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, incentive spirometer, 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, * 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, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 03. Partial/moderate 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 - 06. Independent

OT Goals

PATIENT-STATED GOAL: Pt does not want to be pain, CG wants Pt to be more functional

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

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

Eating - 06. Independent

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 03. Partial/moderate assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/07/2026