Home Health Certification and Plan of Care

Order ID: 1150/17925

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
27241757	03/26/2026	From: 03/26/2026 To: 05/24/2026	23138	217058

6. Patient's Name and Address

Bonita Stockton
3632 LANGREHR ROAD,
WINDSOR MILL, MD 21244-
443-431-0833

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 04/29/1941 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
G89.29	Other chronic pain	03/26/26

13. ICD	Other Pertinent Diagnoses	Date
M54.50	Low back pain unspecified	03/26/26
I10.	Essential (primary) hypertension	03/26/26
E11.65	Type 2 diabetes mellitus with hyperglycemia	03/26/26
J45.20	Mild intermittent asthma uncomplicated	03/26/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	03/26/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	03/26/26
M79.7	Fibromyalgia	03/26/26
F32.A	Depression unspecified	03/26/26
D64.9	Anemia unspecified	03/26/26
I70.0	Atherosclerosis of aorta	03/26/26
M19.90	Unspecified osteoarthritis unspecified site	03/26/26
I47.19	Other supraventricular tachycardia	03/26/26
M06.9	Rheumatoid arthritis unspecified	03/26/26
M32.10	Systemic lupus erythematosus organ or system involv unsp	03/26/26
D69.6	Thrombocytopenia unspecified	03/26/26
E78.5	Hyperlipidemia unspecified	03/26/26
F39.	Unspecified mood [affective] disorder	03/26/26
E55.9	Vitamin D deficiency unspecified	03/26/26
Z79.4	Long term (current) use of insulin	03/26/26
Z79.51	Long term (current) use of inhaled steroids	03/26/26
Z79.82	Long term (current) use of aspirin	03/26/26
Z87.440	Personal history of urinary (tract) infections	03/26/26
Z91.81	History of falling	03/26/26

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

furosemide (LASIX) 20 mg by mouth once a day
FLUoxetine (PROZAC) 0 40 mg by mouth once a day
montelukast (SINGULAIR) 0 10 mg by mouth once a day
gabapentin (NEURONTIN) 0 300 mg by mouth four times a day
metoprolol tartrate (LOPRESSOR) 0 50 mg by mouth twice a day
buPROPion (WELLBUTRIN SR) 0 150 mg by mouth twice a day
atorvastatin (LIPITOR) 0 20 mg by mouth in the evening
fluticasone-salmeterol (ADVAIR) 0 500-50 MCG/ACT inhaler / 1 puff inhalant twice a day RT
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 5,000Unit cap by mouth once a day

14. DME and Supplies:

commode, cane

15. Safety Measures:

diabetic precautions, fall precautions, medication safety, ambulates with device, hand rails, bathroom safety

16. Nutrition:

cardiac diet, diabetic

17. Allergies:

diclofenac sodium tramadol diazepam hydromorphone oxycodone-acetaminoph

18.A. Functional Limitations

Hearing, Ambulation

18.B. Activities Permitted

Cane, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, 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

patient will be responsible for managing treatment
patient will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Other chronic pain, 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 84-year-old female admitted to home health services following a recent hospitalization and subsequent stay at a skilled nursing facility after sustaining a fall at home. During the fall, the patient reports striking her head but denies any fractures. Her past medical history is significant for <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-hypertension">hypertension</mh>, supraventricular tachycardia, asthma, severe obstructive sleep apnea, type 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-18 CE-FMS-diabetes">diabetes</mh> mellitus, chronic low back pain, depression, and a history of recurrent falls. During her recent hospitalization, she was also diagnosed with a urinary tract infection and completed a course of antibiotic treatment prior to discharge. On assessment, the patient is alert and oriented to person, place, time, and situation (A&O x4). She reports persistent lower back pain rated at 9/10 in intensity and describes intermittent shortness of breath related to asthma symptoms, as well as occasional episodes of chest pain. She denies nausea or vomiting and reports her last bowel movement occurred yesterday. Respiratory assessment revealed diminished lung sounds at the right lower base. Cardiovascular and peripheral assessment showed significant bilateral lower extremity edema, with the right lower extremity demonstrating +3 to +4 pitting edema with redness and coolness to touch, and the left lower extremity demonstrating +2 pitting edema also cool to touch. Pedal pulses are faint but palpable bilaterally. Vital signs were obtained and documented at the time of assessment. The patient lives alone in a multi-level home but receives daily assistance from her daughter. Functionally, the patient demonstrates significant mobility limitations and increased fall risk. She reports frequent falls and is considering relocation in the near future due to safety concerns within her current home environment. Although she has historically ambulated within the home without an assistive device, she has been instructed to use a cane or walker for safety. At the time of assessment, she is able to ambulate short household distances with an assistive device and assistance due to decreased endurance, impaired balance, and

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/26/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Faryal Nadeem
7141 Security Blvd
Windsor Mill, MD 21244
PHONE: 800-777-7904 FAX: NPI: 1699138537

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 : 03/07/2026

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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pain-limited mobility. She currently has a cane and a wheelchair in the home but reports that the cane available is not hers and requests a properly fitted replacement. She requires supervision to contact guard assistance for bed mobility and sit-to-stand transfers and standby assistance for toilet transfers with verbal cues for proper limb placement. She requires contact guard assistance for upper body dressing and minimal assistance for lower body dressing tasks. The patient performs bathing at the sink or seated at the edge of the tub. Manual muscle testing indicates bilateral upper extremity weakness with strength approximately 4-/5. Overall presentation includes bilateral lower extremity weakness, impaired standing balance, altered gait mechanics, and decreased activity tolerance. Skilled nursing services are required for ongoing assessment, vital sign monitoring, medication education, and management of chronic medical conditions. The patient will also benefit from continued monitoring of edema, respiratory status, and pain management. Physical therapy services are medically necessary to address deficits in strength, balance, gait training, and functional mobility, with the goal of improving safety, reducing fall risk, and maximizing independence within the home environment. Occupational therapy evaluation and intervention are also indicated to address deficits in activities of daily living, upper extremity strength, and safe transfer techniques. Education has been initiated regarding fall prevention, safe use of assistive devices, and the importance of adhering to mobility recommendations to reduce the risk of further injury. The interdisciplinary plan of care focuses on improving functional mobility, managing pain, monitoring medical status, and supporting the patient's ability to safely remain in the home environment.
 Date of Order 03/26/2026 Orders Physician Face-to-Face Date: 03/07/2026 Clinical Condition Requiring Home Care per Certifying Physician: UTI, Fall, Worsening chest and lower back pain due to Other chronic pain 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: Nadeem, Faryal

SN Careplans

SN WK1: 1 (03/26/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK4: 1 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26)

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: 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 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/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:Refused

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0160 - Depression, D0700 - Social Isolation, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, Home Safety, M2020 - Oral Med Management, lung sounds not clear, dizziness/syncope, delayed capillary refill, swelling in the arms/legs, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, M1610 - Urinary Incontinence, limited strength, limited range of motion, limited endurance, Pain Interference with ADLs, Pain Effect on Sleep, balance deficit, weak hand grips, obesity, pallor, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, glucose testing via monitor, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange repair or installation of adequate stair railings, coordinate/arrange long-term socialization activities

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

SN Goals

PATIENT-STATED GOAL: I don't want to fall anymore.

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 increase socialization
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

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

patient's enviroment has adequate stairs railings

patient is adequately supervised

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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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, * 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, * strategies to increase socialization, related medication(s) purpose, schedule, patient's enviroment has adequate stairs railings, 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 (03/26/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK5: 1 (04/19/26-04/25/26) ,WK6: 1 (04/26/26-05/02/26) ,WK7: 1 (05/03/26-05/09/26) ,WK8: 1 (05/10/26-05/16/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, 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: B LE strengthening: B LE mm strengthening, 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 - 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, Car Transfer - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: not to go back to hospital

GOALS
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

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

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 - 05. Setup or clean-up assistance

OT Careplans

OT WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26) ,WK6: 1 (04/26/26-05/02/26) ,WK7: 1 (05/03/26-05/09/26) ,WK8: 1 (05/10/26-05/16/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, 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: Medication reviewed with patient/caregiver : Medication review , cough/deep breathing exercises, therapeutic exercises, dynamic standing balance exercises, 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent, Patient will demonstrate improved bilateral upper extremity muscle strength from 4-/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

OT Goals

PATIENT-STATED GOAL: Patient wants to get stronger and stop falling

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

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

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

Don/Doff Footwear - 05. Setup or clean-up assistance

Patient will demonstrate improved bilateral upper extremity muscle strength from 4-/5

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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Patient will demonstrate improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

Oral Hygiene - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
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