

Home Health Certification and Plan of Care				Order ID: 1150/18049	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
91359040		04/15/2026		From: 04/15/2026 To: 06/13/2026	
				4. Medical Record No.	
				24817	
				5. Provider No.	
				217058	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Theresa Johnson 2818 HENLEY DR, BEL AIR, MD 21015 410-652-8114			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
03/14/1957			Female		
11. ICD			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
J44.1			FOSAMAX 70 mg Oral monthly Once a month		
Principal Diagnosis			ASPIRIN 81 mg by mouth 1 time daily		
Chronic obstructive pulmonary disease w (acute) exacerbation			LIPITOR 80 mg by mouth 1 time daily HLD		
Date			WELLBUTRIN 100 mg Oral 1 time daily before breakfast Depression		
04/15/26			COLACE 200 mg by mouth 1 time daily Stool softener		
13. ICD			NAMENDA 5 mg 10 mg Oral 2 times daily		
Other Pertinent Diagnoses			METOPROLOL 25 mg Oral 2 times daily		
J96.11			REMERON 45 mg Oral nightly		
Chronic respiratory failure with hypoxia			XARELTO 20 mg Oral 1 time daily		
I11.9			DESYREL 100 mg Oral nightly		
Hypertensive heart disease without heart failure			VITAMIN 1,000 Units by mouth 1 time daily		
I73.9			ALBUTEROL 2.5 mg/3mL nebulizer solution Use 4 times daily for wheezing or shortness of breath		
Peripheral vascular disease unspecified			OXYGEN-HELIUM IN 2 L/min nasal cannula continuous		
F33.1			Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, 1 tablet by mouth every 4 hours As needed for pain		
Major depressive disorder recurrent moderate			Lidocaine Patch - Lidocaine 4%, 3 patches topical once a day pain management		
D64.9			Pantoprazole - Pantoprazole Sodium 40 mg Take 1 tablet by mouth twice a day GERD		
Anemia unspecified					
M54.9					
Dorsalgia unspecified					
G89.29					
Other chronic pain					
F41.9					
Anxiety disorder unspecified					
K21.9					
Gastro-esophageal reflux disease without esophagitis					
E78.00					
Pure hypercholesterolemia unspecified					
Z79.01					
Long term (current) use of anticoagulants					
Z79.82					
Long term (current) use of aspirin					
Z99.81					
Dependence on supplemental oxygen					
Z85.118					
Personal history of malignant neoplasm of bronchus and lung					
Z90.2					
Acquired absence of lung [part of]					
Z86.03					
Personal history of neoplasm of uncertain behavior					
Z87.891					
Personal history of nicotine dependence					
14. DME and Supplies:			15. Safety Measures:		
bath bench, walker, oxygen supplies, cane			standard precautions, fall precautions, ambulates with device, walker precautions, medication safety, bathroom safety, anticoagulant precautions		
16. Nutrition:			17. Allergies:		
low sodium			latex bee venom cayenne iodine magnesium		
18.A. Functional Limitations			18.B. Activities Permitted		
Dyspnea With Minimal Exertion, Ambulation			No Restrictions		
19. Mental & COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Pyschosocial Status: Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes					
20. Prognosis: fair					
22. A Rehabilitation Potential:			22.B.Discharge Plans		
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.			patient will be responsible for managing treatment		
Homebound status: Due to diagnosis of Chronic obstructive pulmonary disease with (acute) exacerbation, 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: <p class="MsoNoSpacing">The patient is a 69-year-old female on continuous oxygen therapy (2-3 L via nasal cannula and concentrator) who was recently hospitalized for abdominal pain and melena and diagnosed with a stomach ulcer, as well as treated for a COPD exacerbation. Her past medical history is significant for COPD, hypertensive heart disease, peripheral vascular disease, anemia, anxiety, gastroesophageal reflux disease, oxygen dependence, lung cancer status post left lung lobectomy, hypercholesterolemia, and a history of smoking (ceased one week ago). She lives with her son in a ranch-style home and was previously independent with activities of daily living and limited community mobility. Currently, she reports fatigue, shortness of breath, occasional nonproductive cough, left-sided neck pain (managed with a prescribed pain patch), and rhinorrhea since increasing oxygen to 3 L; she was advised to request a humidifier attachment. Pursed-lip breathing was observed, and a nebulizer treatment was administered with new equipment setup and patient education, which she understood. She ambulates slowly using furniture at home and a walker outside, with noted lower extremity weakness, impaired balance (Tinetti score 14/28; TUG 16.8 seconds), gait dysfunction, and low endurance; she also reported one fall in the past three months. Fall prevention education, including oxygen tubing safety, was provided. Skin assessment was intact, with a protective sacral dressing removed. Vital signs were within normal limits. Medication reconciliation was incomplete due to unavailable medications, and the patient has not yet established care with a new PCP; although an appointment is scheduled, transportation barriers remain, and alternative transport options were provided. She is motivated to regain strength and return to her prior level of function, with goals including increased mobility and community participation; skilled OT evaluation indicates she is currently independent in self-care and transfers, with no further OT services recommended, though continued PT is advised to address mobility deficits.</o:p></o:p></p> <p class="MsoNoSpacing"><o:p> </o:p></p> <p class="MsoNoSpacing">Date of Order<o:p></o:p></p> <p class="MsoNoSpacing">04/15/2026 Order<o:p></o:p></p> <p class="MsoNoSpacing">Physician Face-to-Face Date: 04/10/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease and medication management, PT eval and treat, OT eval and treat HHA Adl's DX: Chronic obstructive pulmonary disease with (acute) exacerbation Homebound Status per Certifying Physician: patient requires another person or					
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 04/15/2026					
24. Physician's Name and Address			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.		
Sonia Sharma			F2F date : 04/10/2026		
3400 Box Hill Center Dr					
Abingdon, 0 21009					
PHONE: 410-515-5440 FAX: NPI: 1336595925					
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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medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p> <p class="MsoNoSpacing"> 1 - SOC - SN Notes:<o:p></o:p></p> <p class="MsoNoSpacing">PT Eval Notes:<o:p></o:p></p> <p class="MsoNoSpacing">OT Eval Notes:<o:p></o:p></p> <p class="MsoNoSpacing">Physician: /> Sharma, Sonia</p>				

SN Careplans SN WK1: 1 (04/15/26-04/18/26) ,WK2: 1 (04/19/26-04/25/26) ,WK3: 1 (04/26/26-05/02/26) ,WK4: 1 (05/03/26-05/09/26) ,WK5: 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 > 5 CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance HOSPITALIZATION RISKS: 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:Refused PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0160 - Depression, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, tarry/bloody stools, abdominal pain, M1610 - Urinary Incontinence, muscle weakness, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange transportation services 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, * 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, patient's transportation needs are met, meal preparation is available to patient for all meals	SN Goals PATIENT-STATED GOAL: 5o breathe better with ease GOALS 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 * 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 * 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 transportation needs are met meal preparation is available to patient for all meals
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PT Careplans	PT Goals
Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/15/2026

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PT WK1: 1 (04/15/26-04/18/26) ,WK2: 1 (04/19/26-04/25/26) ,WK3: 1 (04/26/26-05/02/26) ,WK4: 1 (05/03/26-05/09/26) ,WK5: 1 (05/10/26-05/16/26) ,WK6: 1 (05/17/26-05/23/26) ,WK7: 1 (05/24/26-05/30/26) ,WK8: 1 (05/31/26-06/06/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, 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: Medication management : Review medication with pt, cough/deep breathing exercises, incentive spirometer, home exercise program: Laq, hip flexion, heelraises, hip abduction, hamstring curls,, 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 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 - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 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, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance			PATIENT-STATED GOAL: Pt would like to get stronger and travel to see her sister in Florida. And would like to goto yard sales. 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 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 - 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 Picking Up Object - 05. Setup or clean-up assistance		
OT Careplans OT WK1: 1 (04/15/26-04/18/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, 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: home exercise program 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 - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent			OT Goals PATIENT-STATED GOAL: Evaluation only GOALS 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 * 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 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		

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