

Home Health Certification and Plan of Care				Order ID: 1150/18295		
1. Patient s HI claim No.		2. Start Of Care Date	3. Certification Period		4. Medical Record No.	5. Provider No.
591281227		04/21/2026	From: 04/21/2026 To: 06/19/2026		4973	217058
6. Patient's Name and Address Frances Reed 710 HOLLY AVENUE, PASADENA, MD 21122- 443-763-0142				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 01/30/1951 9.Sex Female				10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
11. ICD	Principal Diagnosis		Date	Cholecalciferol 125 MCG (5000 UT) Tabs / Take 5,000 Units by mouth once a day Commonly known as: VITAMIN D-3 LACTULOSE 10 GM/15ML solution / Take 10 g by mouth 2 times daily Xifaxan - Rifaximin 550 MG tablet by mouth 2 times daily SPIRONOLACTONE 25 MG tablet by mouth once a day as needed for fluid retention. Commonly known as: ALDACTONE Clindamycin - Clindamycin Hydrochloride 300 MG by mouth every 6 hours Take 1 tab by mouth every 6 hours Spiriva Respimat - Tiotropium Bromide 2.5 MCG/ACT Aers inhaler, Take 2 puffs inhalation daily Generic drug: tiotropium. For: Chronic Bronchitis CYANOCOBALAMIN 1000 MCG/ML Kit / Inject 1,000 mcg Inject every 30 days as directed		
M81.0	Age-related osteoporosis w/o current pathological fracture		04/21/26			
13. ICD	Other Pertinent Diagnoses		Date			
K05.5	Other periodontal diseases		04/21/26			
D72.818	Other decreased white blood cell count		04/21/26			
D69.6	Thrombocytopenia unspecified		04/21/26			
K83.01	Primary sclerosing cholangitis		04/21/26			
K76.6	Portal hypertension		04/21/26			
J44.9	Chronic obstructive pulmonary disease unspecified		04/21/26			
K75.81	Nonalcoholic steatohepatitis (NASH)		04/21/26			
K21.9	Gastro-esophageal reflux disease without esophagitis		04/21/26			
M50.30	Other cervical disc degeneration unsp cervical region		04/21/26			
M79.7	Fibromyalgia		04/21/26			
E78.00	Pure hypercholesterolemia unspecified		04/21/26			
G91.2	(Idiopathic) normal pressure hydrocephalus		04/21/26			
Z93.2	Ileostomy status		04/21/26			
Z87.891	Personal history of nicotine dependence		04/21/26			
14. DME and Supplies: bath bench, hand held shower, ostomy supplies, rolling walker, , cane				15. Safety Measures: transfer with assist, supervision at all times, fall precautions, avoid temperature extremes, ambulates with device, standard precautions, emergency phone number prominently displayed, ambulates with assistance, walker precautions, smoke detectors , bathroom safety, activity supervision		
16. Nutrition: 2gm sodium!low sodium				17. Allergies: demerol gabapentin latex penicillins tramadol tylenol bactrim doxycycline elavil		
18.A. Functional Limitations Endurance, Hearing				18.B. Activities Permitted Cane, Walker, Exercises Prescribed, Transfer bed/Chair, Up As Tolerated		
19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No						
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 Age-related osteoporosis w/o current pathological fracture, 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:	<div>Physical therapy start-of-care (SOC) admission was completed for a 75-year-old female, with all required consents obtained. The patient was recently admitted to the hospital from 04/17/2026 to 04/18/2026 following a fall from bed, which she reports occurred due to feeling overwhelmed. Emergency medical services were contacted by her daughter, and the patient was transported to the hospital. She has since returned home with family support and resides with her spouse, who is available at all times to assist with care. The patient lives in a single-level ranch-style home with two steps required for entry. She ambulates within the home using a cane. The patient reports a history of recurrent falls, including two falls within the past two months and a total of three falls over the past year, and expresses concerns regarding impaired balance. A comprehensive medication reconciliation, home safety assessment, and patient handbook review were completed during the visit. The physical therapy plan of care (POC) was discussed and developed collaboratively with the patient and caregiver. The patient currently presents with multiple functional deficits, including abdominal pain, decreased bilateral lower extremity strength, impaired balance, unsteady gait, reduced functional mobility, difficulty negotiating steps, impaired transfer ability, decreased safety awareness, and a significant fall risk. Objective assessment included administration of the Tinetti and Timed Up and Go (TUG) gait assessments. The patient requires standby assistance (SBA) for transfers and ambulation using a cane, with verbal cueing for proper hand and foot placement, forward weight shift during transfers, and safe positioning when sitting. During ambulation on level surfaces, the patient required SBA and verbal cues to improve bilateral step height and length as well as overall safety. Continued use of a cane with caregiver supervision at all times was strongly recommended. Skilled interventions included patient education on fall prevention strategies, risk factors for falls, and implementation of home safety modifications as outlined in the patient handbook (pages 32-33). The patient was also instructed on safe transfer techniques and ambulation strategies. Education was provided on the importance of daily ambulation to promote circulation and prevent complications associated with immobility. A progressive walking program was initiated, beginning with short walks within the home every 1-2 hours, with longer walks starting at 3-5 minutes and advancing gradually as tolerated. The patient reports that pain is currently well controlled with prescribed medications. She was educated on effective pain management strategies, including taking medications at the onset of pain, premedicating approximately one hour prior to therapy sessions, and monitoring for potential side effects such as dizziness and constipation. The patient was instructed to seek immediate medical attention for chest pain, unrelieved pain, or shortness of breath. She verbalized understanding of all education provided. The patient will receive home physical therapy services beginning 04/21/2026 with a planned frequency of two visits per week for one week, followed by one visit per week for eight weeks. A follow-up appointment is scheduled with Dr. Sharon Chung on 04/27/2026, and the physician has been notified of the patient's admission to home care services. The patient is considered homebound due to a high risk of falls, history of falls, and the requirement for assistive devices and human assistance to safely leave the home. Skilled physical therapy is deemed medically necessary to address deficits in strength, mobility, balance, and safety awareness, with the goal of reducing fall risk and restoring the patient's independence in the home environment.</div><div> </div><div>Date of Order</div><div>04/21/2026</div><div>Orders</div><div>Physician Face-to-Face Date:					
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 04/21/2026				25. Date HHA Received Signed POT		
24. Physician's Name and Address Sharon Chung 7670 Quarterfield Rd Glen Bernie, MD 21061 PHONE: 410-508-7650 FAX: 1-410-508-7701 NPI: 1295026045				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 : 04/18/2026		
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. PAGE 1 of 3		

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04/18/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat due to Age-related osteoporosis w/o current pathological fracture</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div> </div><div>1 - SOC - PT Notes: soc</div><div>Physician</div><div>Chung, Sharon</div>					
SN Careplans			SN Goals		
PT Careplans			PT Goals		
PT WK1: 2 (04/21/26-04/25/26) ,WK2: 1 (04/26/26-05/02/26) ,WK3: 1 (05/03/26-05/09/26) ,WK4: 1 (05/10/26-05/16/26) ,WK5: 1 (05/17/26-05/23/26) ,WK6: 1 (05/24/26-05/30/26) ,WK7: 1 (05/31/26-06/06/26) ,WK8: 1 (06/07/26-06/13/26) ,WK9: 1 (06/14/26-06/19/26)			PATIENT-STATED GOAL: I would like to be able to have more balance while I am walking		
PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 50 > 90, O2 saturation < 88 > 100, pain < 0 > 5			GOALS		
CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance			Chair to Bed to Chair - 06. Independent		
HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 4. Multiple emergency department visits (2 or more) in the past 6 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			Toilet Transfer - 06. Independent		
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.			Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance		
; 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			1 - Step (curb) - 05. Setup or clean-up assistance		
PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170K1 - Walk 150 Feet, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10			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		
			caregiver administers and/or packages medications appropriately		
			caregiver performs medical/rehabilitation treatments with adequate competence		
			Sit to Stand - 06. Independent		
			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		
			Don/Doff Footwear - 06. Independent		
			Lower Body Dressing - 06. Independent		
			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		
			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		
			Oral Hygiene - 06. Independent		
			Toileting Hygiene - 06. Independent		
			Shower/Bathe Self - 04. Supervision or touching assistance		
			Eating - 06. Independent		
Signature of Physician:			Date		
			PAGE 2 of 3		
Optional Name/Signature of Nurse/Therapist:			Date		
Electronically Signed by Messick, Charles RN			04/21/2026		

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Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, abdominal pain, muscle weakness, limited endurance, balance deficit PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., 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., 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, * 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, caregiver performs medical/rehabilitation treatments with adequate competence, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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, 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 - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent			Upper Body Dressing - 06. Independent	

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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