Home Health Certification and Plan of Care

Order ID: 1150/18274

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
36295561	04/23/2026	From: 04/23/2026 To: 06/21/2026	25056	217058

6. Patient's Name and Address

Sybil Jones
244 SHEILA KAY COURT,
SEVERN, MD 21144
410-674-4725

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 01/17/1953 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
G89.11	Acute pain due to trauma	04/23/26

13. ICD	Other Pertinent Diagnoses	Date
M25.551	Pain in right hip	04/23/26
M25.511	Pain in right shoulder	04/23/26
I10.	Essential (primary) hypertension	04/23/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	04/23/26
I25.2	Old myocardial infarction	04/23/26
M10.072	Idiopathic gout left ankle and foot	04/23/26
M47.812	Spondylosis w/o myelopathy or radiculopathy cervical region	04/23/26
F32.A	Depression unspecified	04/23/26
M79.7	Fibromyalgia	04/23/26
E78.00	Pure hypercholesterolemia unspecified	04/23/26
G47.00	Insomnia unspecified	04/23/26
R91.1	Solitary pulmonary nodule	04/23/26
Z86.16	Personal history of COVID-19	04/23/26
Z98.1	Arthrodesis status	04/23/26
Z87.891	Personal history of nicotine dependence	04/23/26

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

CLONAZEPAM 0.5 mg mg by mouth twice a day as needed (anxiety). Commonly known as: KlonoPIN
ROSUVASTATIN CALCIUM 20 mg mg by mouth daily Commonly known as: CRESTOR
QUETIAPINE FUMARATE 100 mg mg by mouth nightly Commonly known as: SEROquel
MULTIVITAMIN 1 tablet by mouth daily
PREGABALIN 150 mg / 1 Capsule by mouth 3 times daily
Hydroxyzine Hydrochloride - Hydroxyzine Hydrochloride 25 mg by mouth 2 times daily
ESOMEPRAZOLE MAGNESIUM 40 mg mg by mouth daily Commonly known as: NexIUM
DULOXETINE HYDROCHLORIDE Delayed Release Particles 30 mg / 1 Capsule by mouth daily Commonly known as: CYMBALTA
SERTRALINE 100 mg/tablet / Take 150 mg by mouth daily Commonly known as: ZOLOFT
CARVEDILOL 6.25 mg mg by mouth 2 times daily Commonly known as: COREG
ACETAMINOPHEN 500 mg/tablet / Take 2 tablets by mouth 3 times daily Commonly known as: TYLENOL
Lidocaine Patch - Lidocaine 4% / Place 1 patch onto the skin topical every 24 hours Do not use before April 18, 2026. Start taking on: April 18, 2026
Diclofenac Sodium - Diclofenac Sodium 0 Gel 1% / Apply 2 g to the skin topical 2 times daily as needed (Knee pain). Commonly known as: VOLTAREN

14. DME and Supplies:

cane, rolling walker

15. Safety Measures:

fall precautions, bathroom safety, standard precautions, , ambulates with device, ambulates with assistance

16. Nutrition:

regular

17. Allergies:

codeine percocet adhesive tape

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

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: 3. Often, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

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: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans

SN: patient will be responsible for managing treatment
PT: patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Acute pain due to trauma, 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 past medical history significant for coronary artery disease (CAD), hypertension, depression, gout, and chronic pain related to arthritis. She was recently admitted to the emergency department following a fall at home while attempting to get into bed, during which she fell onto the side of the bed. The patient reports progressive generalized weakness without a clearly identified cause despite prior hospital evaluation. She denies suicidal ideation but endorses persistent depressive symptoms, including social withdrawal, poor sleep, and decreased appetite. She is followed by psychiatry every three months but reports her current antidepressant regimen as ineffective. Additionally, she missed a recent pain management appointment. Skilled nursing services have been initiated with a focus on medication management and disease process education related to gout, depression, hypertension, and pain management, with a planned visit frequency of 1 week for 1 visit, followed by 2 weeks for 1 visit, and then 1 week for 3 visits. Admission paperwork has been completed, and the patient agrees with the plan of care. Physical therapy evaluation was completed following hospitalization approximately two weeks prior for a fall associated with significant weakness, during which the patient was unable to get up independently. The patient reports a gradual decline in functional mobility over the past year secondary to chronic arthritic pain. Although inpatient rehabilitation was recommended, the patient declined in order to remain at home to assist in the care of her spouse, who is suspected to have Alzheimer's disease or dementia. The patient resides in a mobile home with her spouse, who is present at all times and able to provide assistance as needed; additional family support is also available. The home has three steps to enter. The patient ambulates within the home using a four-wheeled walker and reports three falls within the past two months. On assessment, the patient demonstrates multiple functional impairments, including right hip and left shoulder pain, decreased bilateral lower extremity strength, impaired balance, unsteady gait, decreased safety awareness, difficulty with transfers and stair negotiation, and overall reduced functional mobility, placing her at high risk for falls. She requires minimal assistance to standby assistance for transfers and standby assistance for ambulation with a walker. Standardized assessments, including the Tinetti and Timed Up and Go (TUG), were performed to evaluate fall risk and mobility. The patient was instructed extensively in fall prevention strategies, home safety measures, and safe use of her walker, including proper hand and foot placement, forward weight shifting, and controlled descent when sitting. Education was also provided on the importance of consistent use of the walker for all ambulation. A progressive walking program was initiated, with instructions to perform short walks within the home every 1-2 hours and gradually increase duration from 3-5 minutes as tolerated. The patient was also instructed in pain management techniques, including appropriate timing of pain medication (ideally one hour prior to therapy sessions), monitoring for side effects such as dizziness and constipation, and use of ice therapy to the right hip for 20 minutes with appropriate skin protection and frequent checks. She was advised to seek immediate medical attention for chest pain, unrelieved pain, or shortness of breath. The patient verbalized understanding of all education provided. The patient is considered homebound due to her high fall risk, pain, weakness, and need for human assistance and an assistive device for safe mobility. Leaving the home requires considerable and taxing effort and poses a safety risk. Skilled physical therapy services are indicated and have been initiated with a frequency of 1 visit for 1 week, followed by 2 visits per week for 1 week, then 1 visit per week for 3 weeks, focusing on improving strength, balance, functional mobility, transfer safety, gait, and fall prevention to restore independence. The plan of care was reviewed and agreed upon by the

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/23/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Raphael Dodoo
1916 Crain Highway S #7
Glen Burnie, MD 21061
PHONE: 410-590-3424 FAX: 14105903425 NPI: 1508835497

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 : 04/16/2026

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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patient and caregiver. The referring physician, Dr. Rafael Dodoo, has been notified of the initiation of services. The patient has requested to delay occupational therapy evaluation for 30 days, and this request has been communicated to the physician.
 Date of Order 04/23/2026 Orders Physician Face-to-Face Date: 04/16/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Acute pain due to trauma 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 OT Eval Notes: PT Eval Notes: Physician Dodoo, Raphael

SN Careplans

SN WK1: 1 (04/23/26-04/25/26) ,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)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, D0700 - Social Isolation, Financial, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited endurance, limited range of motion, lethargy, balance deficit, weak hand grips, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange preparation of missing meals, coordinate/arrange access to adequate food storage, coordinate/arrange patient access to necessary nutrition considering patient inability to pay, 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 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, * strategies to increase socialization, related medication(s) purpose, schedule, patient has access to necessary nutrition considering patient inability to pay, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: I like to get my life back in order, cook meals and take care of my husband by getting this pain and weakness under control

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

patient has access to necessary nutrition considering patient inability to pay

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/23/2026

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PT Careplans

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PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, Pain Effect on Sleep, 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, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

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 Bil shoulders, R hip and L knee 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., 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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 - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To get back to being able to do the things I used to do, and to get strong again.

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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 - 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

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

Oral Hygiene - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

04/23/2026