

Home Health Certification and Plan of Care				Order ID: 1150/18507	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
49115221		05/07/2026		From: 05/07/2026 To: 07/05/2026	
				4. Medical Record No.	
				25610	
				5. Provider No.	
				217058	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Linda Brotzman 2227 Vailthorn Rd, MIDDLE RIVER, MD 21220- 410-574-1284			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
05/03/1948			Female		
11. ICD			Date		
Z48.3			Aftercare following surgery for neoplasm		
			05/07/26		
13. ICD			Date		
C71.1			Malignant neoplasm of frontal lobe		
S24.113D			Complete lesion at T7-T10 subs		
I10.			Essential (primary) hypertension		
E78.5			Hyperlipidemia unspecified		
N20.0			Calculus of kidney		
I70.0			Atherosclerosis of aorta		
M89.59			Osteolysis multiple sites		
M89.8X9			Other specified disorders of bone unspecified site		
E63.9			Nutritional deficiency unspecified		
C90.30			Solitary plasmacytoma not having achieved remission		
G47.00			Insomnia unspecified		
L82.1			Other seborrheic keratosis		
N39.46			Mixed incontinence		
E66.01			Morbid (severe) obesity due to excess calories		
Z79.52			Long term (current) use of systemic steroids		
Z85.828			Personal history of other malignant neoplasm of skin		
Z96.653			Presence of artificial knee joint bilateral		
			05/07/26		
14. DME and Supplies:			15. Safety Measures:		
rolling walker, wheelchair, grab bars, cane, bath bench			walker precautions, transfer with assist, supervision at all times, standard precautions, fall precautions, hand rails, ambulates with device, ambulates with assistance, activity supervision, Spinal precautions		
16. Nutrition:			17. Allergies:		
regular			iodine biaxin claritin iodine compounds		
18.A. Functional Limitations			18.B. Activities Permitted		
Dyspnea With Minimal Exertion, Ambulation, Bowel/Bladder Incontinence			Walker, Up As Tolerated		
19. Mental & Pyschosocial Status:			COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 1. Rarely, 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 required2. 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:			good		
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.			PT: family/caregiver will be responsible for managing treatment OT: patient will		
Homebound status:					
Due to diagnosis of Aftercare following surgery for neoplasm, 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">A 78-year-old female was referred to home health services following hospitalization and subacute rehabilitation after presenting with slurred speech on 3/27/26 and being diagnosed with a right frontal lobe neoplasm, T7-T10 lesion, and multifocal osteolysis. She underwent a right craniotomy and thoracic spine tumor decompression with reconstruction and is scheduled to follow up with oncology tomorrow to determine further treatment. Her past medical history is significant for urinary incontinence, skin cancer, bilateral total knee replacements, obesity, hypertension, hyperlipidemia, and atherosclerosis of the aorta. The patient resides with her husband in a two-story row home with five steps to enter; however, he is unable to assist with her care, and her daughter, who is temporarily assisting, will be leaving within one week. Prior to hospitalization, the patient was independent with ambulation, ADLs, and IADLs without an assistive device. She currently has spinal precautions, with her spinal incision noted to be clean, dry, and intact with sutures in place. During evaluation, the patient demonstrated mild confusion, occasional unusual behaviors, poor safety awareness, impulsivity, lower extremity weakness, impaired balance and coordination, unsteady gait, poor rolling walker management, and difficulty negotiating stairs, placing her at high risk for falls. Education and training were provided to the patient and daughter regarding log rolling, side-lying to sitting techniques, spinal precautions, stair negotiation, safe guarding techniques, walker adjustment, and environmental modifications to improve safety. Additionally, the patient presents with decreased standing balance, standing tolerance, bilateral upper extremity strength, and activity tolerance, resulting in reduced independence with self-care, functional transfers, and mobility. Skilled physical and occupational therapy services are recommended to address these deficits and maximize safety and functional independence with the goal of returning the patient to her prior level of function.</p></p></p> <p class="MsoNoSpacing"></p></p></p> <p class="MsoNoSpacing">Date of Order</p></p></p> <p class="MsoNoSpacing">05/07/2026
 Order</p></p></p> <p class="MsoNoSpacing">Physician Face-to-Face Date: 04/28/2026
 Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat OT-eval & treat DX: Aftercare following surgery for neoplasm
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</p></p></p> <p class="MsoNoSpacing">
 1 - SOC - PT Notes:</p></p></p> <p class="MsoNoSpacing">OT Eval Notes: </p></p></p> <p					
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 05/07/2026					
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.	
Binu Batajoo Shrestha 1447 York Rd Lutherville, MD 21093 PHONE: 4109337600 FAX: 14109337666 NPI: 1972850980				F2F date : 04/28/2026	
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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class="MsoNoSpacing">Physician: Batajoo Shrestha, Binu</p>						
SN Careplans			SN Goals			
PT Careplans			PT Goals			
PT WK1: 1 (05/07/26-05/09/26) ,WK2: 2 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26) ,WK4: 1 (05/24/26-05/30/26) ,WK5: 1 (05/31/26-06/06/26) ,WK6: 1 (06/07/26-06/13/26) ,WK7: 1 (06/14/26-06/20/26) ,WK8: 1 (06/21/26-06/27/26) ,WK9: 1 (06/28/26-07/04/26) 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 > 6 CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance HOSPITALIZATION RISKS: 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, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8 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:*** SEE MOLST *** PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk			PATIENT-STATED GOAL: To improve my balance and walking get up steps easier 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 Shower/Bathe Self - 05. Setup or clean-up assistance patient/caregiver recalls * how to achieve wound healing including cleaning and dressing wound * position changes * skin care * diet modification * record wound measurements * 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 * 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 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 * 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 * 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			
Signature of Physician:			Date			
Optional Name/Signature of Nurse/Therapist:			Date			
Electronically Signed by Messick, Charles RN			05/07/2026			

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10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, M1720 - Anxiety, D0160 - Depression, M1745 - Behavioral Issues, M2020 - Oral Med Management, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, M1610 - Urinary Incontinence, limited strength, limited endurance, muscle weakness, impaired speech, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, balance deficit, difficulty sleeping, daytime fatigue, obesity, #1 - Observable Surgical Wound - Posterior Midline - Open to air no wound care orders listed, sutures are intact PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Posterior Midline - Open to air no wound care orders listed, sutures are intact, Medication management : Review medication with caregiver, cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: Incision open to air, home exercise program: Seated hip abduction, laq, standing as tolerated at kitchen sink for hip flexion, hamstring curls, heelraises, hip extension, equipment training: Work safe mgmt of rw, work simplification/energy conservation, dynamic standing balance exercises: Trg improved righting reaction, wt shifting and reaching outside BOS. Step strategies to prevent lob, gait training on uneven surfaces, gait training/stair training: Train dtr to safely spot pt on steps, 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, * 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, * 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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, 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 - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper 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 caregiver administers and/or packages medications appropriately caregiver performs medical/rehabilitation treatments with adequate competence 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 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 Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent
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OT Careplans OT WK2: 1 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26) ,WK4: 1 (05/24/26-05/30/26) ,WK5: 1 (05/31/26-06/06/26) ,WK6: 1 (06/07/26-06/13/26) ,WK7: 1 (06/14/26-06/20/26) PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing PROCEDURES: Medication Review : Medication reviewed with patient with all medications in the home, cough/deep breathing exercises, incentive spirometer, home exercise program: Bilateral UE strengthening of anterior deltoid, biceps and triceps muscles, work simplification/energy conservation, transfers training: Skilled OT 1x6wks, assist with bathing: Skilled OT 1x6wks, assist with lower body dressing: Skilled OT 1x6wks, assist with upper body dressing: Skilled OT 1x6wks 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent	OT Goals PATIENT-STATED GOAL: Get in the shower 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 Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Shower/Bathe Self - 06. Independent Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent
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Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/07/2026