

Home Health Certification and Plan of Care				Order ID: 1150/18606	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
651043354		05/05/2026		From: 05/05/2026 To: 07/03/2026	
4. Medical Record No.		5. Provider No.			
25483		217058			
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Denise Holloway 6001 Park Heights Avenue Apt 3B, BALTIMORE, MD 21215- 443-712-3128			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB 06/12/1951 9.Sex Female			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
11. ICD Principal Diagnosis Date			NEURONTIN 300 mg / 1 Capsule by mouth daily at bedtime		
M48.02 Spinal stenosis cervical region 05/05/26			ACETAMINOPHEN 500 mg / 1 Tablet by mouth every 6 hours as needed		
13. ICD Other Pertinent Diagnoses Date			LIPITOR 4 mg / 1 Tablet by mouth daily for cholesterol and heart protection		
M54.9 Dorsalgia unspecified 05/05/26			Hydrochlorathiazide - Hydralazine Hydrochloride: Hydrochlorothiazide 25 mg tablet, take 1/2 tablet by mouth once a day Blood pressure		
Z98.1 Arthrodesis status 05/05/26			Klor-Con M20 - Potassium Chloride 20 mEq / 1 Tablet by mouth once a day swallow whole or dissolve in water		
Z79.82 Long term (current) use of aspirin 05/05/26			LIDODERM 5 % Top PTMD Patch / Apply to area of pain topical as necessary for 12 hours on. 12 hours off		
Z91.81 History of falling 05/05/26					
14. DME and Supplies:			15. Safety Measures:		
rolling walker			walker precautions, fall precautions, standard precautions, ambulates with device		
16. Nutrition:			17. Allergies:		
regular			no known allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
Ambulation			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: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No					
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.			SN: patient will be responsible for managing treatment PT: patient will be responsible for managing treatment OT: family/caregiver will be responsible for managing treatment		
Homebound status: Due to diagnosis of Spinal stenosis cervical region, 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>Patient is a 74-year-old female with a past medical history significant for hypertension, hyperlipidemia, cervical fusion, cervical stenosis, recent motor vehicle accident, and left ankle fracture. Patient is currently homebound due to weakness, unsteady gait, impaired mobility, and increased fall risk. Leaving the home requires considerable and taxing effort, and patient requires the use of an assistive device as well as human assistance for safety during community mobility. Patient ambulates with a rollator walker and demonstrates impaired ability to safely grip the device with the left hand secondary to left upper extremity weakness. No complaints of pain or discomfort were voiced during the visit. Patient was alert and oriented to person, place, and time. Skin assessment revealed skin warm, dry, and intact with no noted abnormalities. Physical therapy evaluation was completed. Prior to recent hospitalization and decline in function, patient was independent with ambulation and activities without the use of an assistive device. Patient was recently hospitalized following a fall related to cervical stenosis, compounded by injuries sustained in a recent motor vehicle accident and left ankle fracture. Current assessment revealed significant bilateral lower extremity weakness with manual muscle testing graded at 2-/5. Patient requires contact guard assistance for transfers and short-distance ambulation using a rollator walker. Functional mobility is primarily limited by left upper extremity weakness affecting grip and stability on the assistive device, as well as significant fear of falling. Patient is currently awaiting surgical intervention for cervical stenosis, which was initially scheduled but subsequently postponed and rescheduled. Due to anxiety regarding spinal movement and fear of further injury, patient is hesitant with mobility and functional activities. Continued skilled physical therapy services are recommended following surgical repair to address strength deficits, gait training, balance, transfer safety, endurance, and fall prevention. Occupational therapy evaluation was also completed. Patient resides alone in a senior apartment complex with elevator access. Prior to the recent decline in condition, patient was independent with activities of daily living and ambulation without an assistive device. Patient reported significant emotional distress related to the postponement of scheduled neck surgery and was tearful throughout the evaluation, expressing anxiety and concern regarding her current condition and functional decline. Due to impaired mobility and weakness, patient is currently sleeping in the living room and utilizing a bedside commode to minimize ambulation demands. Patient performs sponge bathing at the bathroom sink and ambulates only short distances as tolerated. Occupational therapy services are planned every other week for the duration of the episode of care to address ADL retraining, adaptive equipment training, functional mobility, therapeutic exercise as tolerated following surgery, homemaking tasks, and home safety education. Patient was educated regarding fall prevention strategies, safe use of assistive devices, energy conservation techniques, and the importance of requesting assistance with mobility as needed. Continued skilled nursing and therapy services remain medically necessary to monitor patient status, reduce fall risk, improve functional independence, and support recovery following anticipated surgical intervention.</div><div> </div><div>Date of Order</div><div>05/05/2026</div><div>Orders</div><div>Physician Face-to-Face Date: 04/27/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat, hha-adl's, msw due to Spinal stenosis cervical region</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><div>1 - SOC - SN Notes: soc</div><div>PT Eval Notes:</div><div>OT Eval Notes:</div><div> </div><div>Physician</div><div>Khai, Gin</div></div>					
SN Careplans			SN Goals		
SN WK1: 1 (05/05/26-05/09/26) ,WK2: 1 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26) ,WK4: 1 (05/24/26-05/30/26) ,WK6: 1 (06/07/26-06/13/26) ,WK8: 1 (06/21/26-06/27/26)			PATIENT-STATED GOAL: Walk better and less pain to continue being independent		
PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100, 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			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		
CAREGIVER: 0. No assistance needed - patient is independent or does not have needs in this area			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,		
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications					
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					
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 05/05/2026					
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.		
Gin Khai 7670 Quarterfield Rd Glen Burnie, MD 21061 PHONE: 410-508-7650 FAX: NPI: 1003443078			F2F date : 04/27/2026		
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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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: M2020 - Oral Med Management, M1400 - Dyspnea, muscle weakness, Pain Interference with ADLs, B1000 - Vision Deficit PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange resources for vision-impaired 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, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule		treatments, and what works best to relieve pain * teach relaxation skills and diversional activities * recalls related medication(s) purpose, schedule patient/caregiver recalls * how to keep home safe for patient with vision loss including eliminating hazards * enhancing lighting * using mechanical aids patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule		
PT Careplans		PT Goals		
PT WK1: 1 (05/05/26-05/09/26) ,WK3: 1 (05/17/26-05/23/26) ,WK5: 1 (05/31/26-06/06/26) ,WK7: 1 (06/14/26-06/20/26) ,WK9: 1 (06/28/26-07/03/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface PROCEDURES: Medication Review: - medications reviewed with patient/caregiver. cough/deep breathing exercises, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed. Upgrade as tolerated, 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 - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 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, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance		PATIENT-STATED GOAL: To be able to walk without help 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 Sit to Stand - 05. Setup or clean-up assistance Chair to Bed to Chair - 05. Setup or clean-up assistance Toilet Transfer - 05. Setup or clean-up assistance 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		
Signature of Physician:		Date		
		PAGE 2 of 3		
Optional Name/Signature of Nurse/Therapist:		Date		
Electronically Signed by Messick, Charles RN		05/05/2026		

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		4 Steps - 04. Supervision or touching assistance Picking Up Object - 04. Supervision or touching assistance Car Transfer - 05. Setup or clean-up assistance Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance	
OT Careplans OT WK1: 6 (05/05/26-05/09/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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: cough/deep breathing exercises, incentive spirometer, home exercise program: Per physician isnructions, home exercise program: Per physician instructions, equipment training, work simplification/energy conservation, transfers training: Tub, toilet 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 - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent		OT Goals PATIENT-STATED GOAL: To have good balance 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 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	

Signature of Physician:		Date	
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