Home Health Certification and Plan of Care

Order ID: 1150/18821

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
32743330	05/19/2026	From: 05/19/2026 To: 07/17/2026	25694	217058

6. Patient's Name and Address

Patricia Bedwell
903 Swallow crest Court Apt E,
EDGEWOOD, MD 21040-
443-640-7740

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 09/10/1941 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M80.021D	Age-rel osteopor w crnt path fx r humer 7thD	05/19/26

13. ICD	Other Pertinent Diagnoses	Date
G20.B1	Parkinson's dis with dyskinesia w/o mention of fluctuations	05/19/26
G89.29	Other chronic pain	05/19/26
I11.9	Hypertensive heart disease without heart failure	05/19/26
F03.94	Unspecified dementia unspecified severity with anxiety	05/19/26
F03.918	Unsp dementia unsp severity with other behavioral disturb	05/19/26
F33.1	Major depressive disorder recurrent moderate	05/19/26
E78.2	Mixed hyperlipidemia	05/19/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	05/19/26
N32.81	Overactive bladder	05/19/26
J30.2	Other seasonal allergic rhinitis	05/19/26
Z79.82	Long term (current) use of aspirin	05/19/26
Z91.81	History of falling	05/19/26

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

MULTIVITAMIN Give 1 tablet by mouth one time a day for supp
ACETAMINOPHEN Extra Strength 500 mg/tablet / Give 2 tablet by mouth three times a day for pain do not exceed 3 grams daily
ASPIRIN Chewable 81 mg / 1 Tablet by mouth one time a day for prophlaxis
ATORVASTATIN 40 mg / 1 Tablet by mouth at bedtime for elevated cholesterol
Carbidopa And Levodopa - Carbidopa: Levodopa 25-100 mg/tablet / Give 1.5 tablet by mouth three times a day for ANTIPARKINSON
Calcium Carbonate 1500 (600 Ca) mg / 1 Tablet by mouth twice a day for supp
DONEPEZIL HYDROCHLORIDE 10 mg 10 mg / 1 Tablet by mouth in the evening for dementia
HYDROMORPHONE HYDROCHLORIDE 2 mg 2 mg / 1 Tablet by mouth every 4 hours as needed for pain
LORATADINE 10 mg 10 mg / 1 Tablet by mouth one time a day for allergy symptoms
LOSARTAN POTASSIUM 25 mg 25 mg / 1 Tablet by mouth once a day for htn hold if sbp is less than 110 HR less then 55
Metoprolol Succinate - Metoprolol Succinate Extended Release 24 Hour 25 mg / 1 Tablet by mouth once a day for htn hold if sbp is less than 110 and hr is less than 55
Polyethylene Glycol 3350 - Polyethylene Glycol 3350 Powder 17 GM/SCOOP / Give 1 scoop by mouth every 24 hours as needed for bowel regimen
SERTRALINE 100 mg / 1 Tablet by mouth one time a day for depression
Fish Oil - Cod Liver Oil 1200 mg / 1 Capsule by mouth one time a day for supp
Glucosamine Chondroitin - Glucosamine 500-400 mg / 1 Tablet by mouth once a day for prophylaxis
Flonase Allergy Relief - Fluticasone Propionate Nasal Suspension 50 MCG/ACT / 1 spray in both nostrils one time a day for Allergy

14. DME and Supplies:

wheelchair, rolling walker, hand held shower, bath bench, walker, grab bars, commode, cane, 4 wheeled walker

15. Safety Measures:

wheelchair precautions, standard precautions, hand rails, fall precautions, , bleeding precautions, ambulates with device, walker precautions, smoke detectors , , medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, supervision at all times, medical alert/lifeline, cardiac precautions, bathroom safety, anticoagulant precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

oxycodone

18.A. Functional Limitations

Ambulation, Bowel/Bladder Incontinence, Endurance

18.B. Activities Permitted

Wheelchair, Walker, Exercises Prescribed, 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: 2. Sometimes, 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 required!2. 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:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

SN: family/caregiver will be responsible for managing treatment
PT; family/caregiver will be responsible for managing treatment
OT: patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Age-related osteoporosis with current pathological fracture, right humerus, subsequent encounter for fracture with routine healing, 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: Patient is an 84-year-old female referred to home health services following recent hospitalization and subsequent skilled nursing facility/subacute rehabilitation stay after a mechanical fall associated with transient right-sided weakness. Past medical history is significant for chronic right proximal humerus fracture, hypertension, hypertensive heart disease, hyperlipidemia, coronary artery disease, osteoporosis, recurrent falls, depression, neurocognitive disorder/dementia, and suspected Parkinson's disease without formal diagnosis. During hospitalization, patient underwent comprehensive neurologic evaluation due to concern for possible cerebrovascular accident or transient ischemic attack. Initial NIH Stroke Scale score was 1, which improved to 0 shortly after arrival with complete resolution of neurologic symptoms. CT imaging of the head, neck, and cervical spine revealed no acute intracranial abnormalities, infarction, or cervical injury. Symptoms were ultimately attributed to Parkinsonian features with gait instability rather than acute CVA or TIA. During acute hospitalization, patient was managed symptomatically for chronic right shoulder pain and right chest wall pain with acetaminophen, lidocaine patches, and PRN opioid therapy. Patient remained on carbidopa-levodopa and donepezil, with recommendations for outpatient neurology follow-up for ongoing Parkinson's disease evaluation and management. Hospital course was additionally notable for constipation, which improved with bowel regimen, and breast intertrigo treated with topical nystatin. Mild leukocytosis was noted without identifiable infectious source or clinical decline. Patient remained hemodynamically stable throughout hospitalization and was subsequently transferred to subacute rehabilitation for continued PT/OT and nursing care prior to discharge home. Patient currently resides in a second-floor condominium/apartment with her husband, requiring negotiation of more than 15 stairs with a single handrail for home entry. Husband continues to work full time but remains involved in patient care, with

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/19/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Lindsey Kruk
104 Plumtree Rd Ste 102
Bel Air, MD 21015
PHONE: 4105699444 FAX: 14105694368 NPI: 1679610794

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 : 04/29/2026

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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intermittent assistance also provided by the patient's daughter and a nearby friend. Patient is designated as full code. Prior to recent hospitalization, patient ambulated with a rolling walker and was independent with bed mobility, transfers, and basic self-care activities; however, family reports patient frequently forgets to use her walker, contributing to recurrent falls and safety concerns. Upon home health assessment, patient demonstrated significant decline in mobility, balance, endurance, and functional independence. Physical therapy evaluation revealed impaired gait with intermittent freezing episodes and festinating gait pattern consistent with Parkinsonian features. Patient demonstrated lower extremity weakness, impaired transfer ability, difficulty negotiating stairs, and decreased safety awareness during ambulation. Objective testing revealed a Tinetti balance and gait assessment score of 8/28 and Timed Up and Go (TUG) score of 32 seconds, indicating high fall risk and severely impaired mobility. Patient continues to ambulate with a rolling walker but requires increased supervision and cueing for safety. Skilled physical therapy services are medically necessary to address gait instability, balance deficits, lower extremity weakness, transfer impairment, stair negotiation, fall prevention, and functional mobility training with goal of maximizing independence and reducing risk for future falls and hospitalization. Occupational therapy evaluation further identified decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, impaired activity tolerance, and decline in ability to complete self-care and functional mobility tasks safely and independently. Patient demonstrates difficulty performing activities of daily living, transfers, and household mobility compared to prior level of function. Skilled occupational therapy services are recommended to improve functional strength, endurance, safety awareness, ADL performance, transfer techniques, and energy conservation strategies to facilitate return toward prior level of functioning and improve overall quality of life. Skilled nursing services initiated for continued medical monitoring, neurologic assessment, medication management, pain management, bowel regimen monitoring, skin integrity assessment, reinforcement of fall precautions, and caregiver education. Patient instructed to continue all prescribed medications as ordered and participate in PT/OT rehabilitation program as tolerated. Fall prevention and home safety education reinforced with patient and caregivers, including consistent use of rolling walker, supervision during mobility tasks, and environmental safety modifications to reduce fall risk. Patient will continue to be monitored closely for neurologic changes, worsening gait instability, pain, constipation, skin issues, and overall functional decline.
 Date of Order 05/19/2026 Orders Physician Face-to-Face Date: 04/29/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Age-related osteoporosis with current pathological fracture, right humerus, subsequent encounter for fracture with routine healing 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 PT Eval Notes: OT Eval Notes:
 Physician Kruk, Lindsey

SN Careplans

SN WK1: 1 (05/19/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/12/26)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 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

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

SN Goals

PATIENT-STATED GOAL: Patient states she wants to be able to walk around her building again

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
* 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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase socialization
* 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

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
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new/change meds
Advance Directive:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, D0160 - Depression, M1720 - Anxiety, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, A1250 - Lack of Necessary Transportation, D0700 - Social Isolation, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, muscle weakness, limited strength, limited endurance, limited range of motion, swelling of affected area, daytime fatigue, balance deficit, weak hand grips, obesity

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange long-term socialization activities, 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, * 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, * 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's transportation needs are met, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (05/19/26-05/23/26) ,WK2: 2 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/12/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Medication management : Review medication with patient, home exercise program: Laq, Standing hip flexion, hamstring, curls, tip abduction, heel and toe raises. Hip extension, dynamic standing balance exercises: Work on hip, ankle and step strategies to improve ability to correct loss of balance and reduce fall risk., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 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

PT Goals

PATIENT-STATED GOAL: To get stronger, be able to walk easier so I don't fall be able to use my right arm more.

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

OT Careplans

OT WK1: 1 (05/19/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/12/26)

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: Medication Review : Medication reviewed with patient with all medications in the home, home exercise program: Bilateral UE strengthening of deltoid, biceps, triceps and pectoral muscles, equipment training, work simplification/energy conservation, strengthening exercises: Skilled OT 1x5wks, transfers training: Skilled OT 1x5wks, assist with bathing: Skilled OT 1x5wks, assist with lower body dressing: Skilled OT 1x5wks

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,

OT Goals

PATIENT-STATED GOAL: Get in the shower

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

Signature of Physician:	Date
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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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

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