Home Health Certification and Plan of Care

Order ID: 1150/18994

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1R50Q71GR17	05/22/2026	From: 05/22/2026 To: 07/20/2026	25939	217058

6. Patient's Name and Address
Judith Geiger
701 Dorchester Road Unit 2,
Baltimore, MD 21229-
443-869-6588

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 11/06/1948 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
T40.2X2D	Poisoning by oth opioids intentional self-harm subs encntr	05/22/26

13. ICD	Other Pertinent Diagnoses	Date
M62.81	Muscle weakness (generalized)	05/22/26
I10.	Essential (primary) hypertension	05/22/26
D50.9	Iron deficiency anemia unspecified	05/22/26
M48.00	Spinal stenosis site unspecified	05/22/26
G89.29	Other chronic pain	05/22/26
F33.9	Major depressive disorder recurrent unspecified	05/22/26
F41.9	Anxiety disorder unspecified	05/22/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/22/26
M19.90	Unspecified osteoarthritis unspecified site	05/22/26
G95.9	Disease of spinal cord unspecified	05/22/26
R26.0	Ataxic gait	05/22/26
S14.109S	Unsp injury at unsp level of cervical spinal cord sequela	05/22/26
E78.5	Hyperlipidemia unspecified	05/22/26
N39.46	Mixed incontinence	05/22/26
R63.4	Abnormal weight loss	05/22/26
Z87.891	Personal history of nicotine dependence	05/22/26
Z79.899	Other long term (current) drug therapy	05/22/26

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

Meloxicam - Meloxicam 15 mg by mouth once a day
Pantoprazole Sodium - Pantoprazole Sodium 40 mg by mouth before meal
Pravastatin - Pravastatin Sodium 50 mg by mouth once a day
Preservision - Normal Saline 2 caps by mouth once a day
Multivitamins - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tablet by mouth once a day
probiotics 1 capsule by mouth once a day
Benfotiamine 1 capsule 300 mg by mouth once a day Supplement
Fluoxetine - Fluoxetine Hydrochloride eq 20 mg base 3 capsules by mouth in the morning Depression
Abilify - Aripiprazole 10 mg 1 tablet by mouth at bedtime Depression
Lyrica - Pregabalin 100 mg 1 capsule by mouth three times a day Nerve pain
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 capsule 50 mcg by mouth once a day Supplement
Ibuprofen - Ibuprofen 800 mg 1 tablet by mouth every 8 hours Pain as needed

14. DME and Supplies:
cane

15. Safety Measures:
medication safety, standard precautions, fall precautions, ambulates with device

16. Nutrition:
cardiac diet

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation,

18.B. Activities Permitted
Cane

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

20. Prognosis: fair

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: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 Poisoning by other opioids, intentional self-harm, subsequent encounter, 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:

Start of Care (SOC), Physical Therapy (PT), and Occupational Therapy (OT) evaluations were completed for a 77-year-old female referred to home health services following a recent hospitalization for polypharmacy-related altered mental status and functional decline. The patient's past medical history is significant for hypertension (HTN), hyperlipidemia (HLD), gastroesophageal reflux disease (GERD), spinal stenosis with a history of spinal cord injury and neuropathy, degenerative joint disease (DJD), muscle wasting/atrophy, major depressive disorder, anxiety, cervical fusion, and right total shoulder arthroplasty performed approximately four years ago. The patient was also hospitalized at the end of March due to a severe headache and possible seizure and subsequently completed a five-week rehabilitation stay prior to returning home. The patient lives alone in a second-floor apartment and receives intermittent assistance from neighbors as needed. She is homebound due to spinal stenosis, muscle weakness and atrophy, anxiety, DJD, impaired balance, and an unsteady gait, which significantly increase her risk for falls and make leaving the home difficult and taxing. The patient ambulates with an assistive device and requires human assistance when leaving the home. Prior to her recent hospitalization, she primarily ambulated with a single-point cane (SPC) and reported being mostly independent with mobility and daily activities. Currently, she continues to use a cane for indoor ambulation and a rolling walker for outdoor mobility. Upon assessment, the patient was alert and oriented to person, place, and time. Skin was warm, dry, and intact with the exception of a healing skin tear to the left shin sustained during a recent fall approximately one week after returning home. The patient reported losing her balance but was unable to recall the exact date of the incident. The wound is currently covered with a bandage and shows no reported complications. Respirations were even and unlabored with no signs or symptoms of respiratory distress or shortness of breath. The patient denied pain at the time of the visit, although she reported a history of intermittent chronic pain affecting her bilateral lower extremities and lower back. Physical therapy evaluation revealed significant bilateral lower extremity weakness, with manual muscle testing graded at 3-/5. The patient currently requires contact guard assistance for transfers and short-distance ambulation with a single-point cane. She demonstrates impaired balance, decreased strength, reduced endurance, and diminished functional mobility, contributing to an elevated fall risk. Occupational therapy evaluation indicated that the patient remains independent with basic self-care activities and homemaking tasks; however, her history of falls, recent hospitalization, weakness, and mobility limitations place her at risk for further functional decline and injury. Skilled physical therapy services are medically necessary to address deficits in strength, balance, gait, endurance, transfers, and overall functional mobility. Interventions will focus on therapeutic exercise, gait training, balance activities, transfer training, fall prevention strategies, and patient education to improve safety and maximize independence. Skilled occupational therapy services are also indicated and will be provided every other week to address activities of daily living (ADL) training, adaptive equipment education, home exercise program instruction, therapeutic exercise, functional mobility training, and home safety education. The overall goal of home health services is to improve the patient's strength, safety, and functional independence, reduce fall risk, and facilitate a return to her prior level of function within the home and community environment.
 Date of

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/22/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Luciana Veiga
4660 Wilkins Ave Ste 100
Baltimore, MD 21227
PHONE: 4102470782 FAX: 18662515693 NPI: 1285897322

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 : 05/06/2026

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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Order 05/22/2026 Orders Physician Face-to-Face Date: 05/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Poisoning by other opioids, intentional self-harm, subsequent encounter 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 Veiga, Luciana

SN Careplans

SN WK1: 1 (05/22/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK6: 1 (06/21/26-06/27/26) ,WK7: 1 (06/28/26-07/04/26) ,WK8: 1 (07/05/26-07/11/26)

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

CAREGIVER: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (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
Advance Directive:see MOLST

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, headache, 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, * 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, * 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

SN Goals

PATIENT-STATED GOAL: Patient to feel better

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
* 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
* 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 keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/22/2026

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7. Provider's Name, Address and Telephone Number
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Owings Mills, MD 21117-8284
410-321-8448
1487113239

PT WK2: 1 (05/24/26-05/30/26) ,WK4: 1 (06/07/26-06/13/26) ,WK6: 1 (06/21/26-06/27/26) ,WK8: 1 (07/05/26-07/11/26) ,WK10: 1 (07/19/26-07/20/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, 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, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: 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 - 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, Car Transfer - 05. Setup or clean-up assistance

PATIENT-STATED GOAL: To be able to walk with SPC

GOALS
Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

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 - 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

Car Transfer - 05. Setup or clean-up assistance

OT Careplans

OT WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK5: 1 (06/14/26-06/20/26) ,WK7: 1 (06/28/26-07/04/26) ,WK9: 1 (07/12/26-07/18/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400, 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, equipment training, work simplification/energy conservation

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 better 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

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
05/22/2026