Home Health Certification and Plan of Care

Order ID: 1150/18991

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
961059578	05/26/2026	From: 05/26/2026 To: 07/24/2026	20708	217058

6. Patient's Name and Address

Juanita Dillard
3125 Saint Lukes Lane,
GWYNN OAK, MD 21207-
410-298-6258

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 08/17/1929 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M48.061	Spinal stenosis lumbar region without neurogenic claud	05/26/26

13. ICD	Other Pertinent Diagnoses	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	05/26/26
N18.31	Chronic kidney disease stage 3a	05/26/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/26/26
E03.9	Hypothyroidism unspecified	05/26/26
Z79.82	Long term (current) use of aspirin	05/26/26
Z91.81	History of falling	05/26/26

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

Aspirin - Aspirin 81 MG TAB, DELAYED RELEASE,1 tablet by mouth once a day 1 tablet every day
prophylaxis
Inderal - Propranolol Hydrochloride 20 mg **federal register determination that product was not discontinued or withdrawn for safety or efficacy reasons** 20 mg Oral Tab,Take 1 tablet by mouth twice a day Take 1 tablet by
mouth 2 times a day
blood pressure
Roxicodone - Oxycodone Hydrochloride 5 mg 5 mg Oral Tab,Take 1 tablet by mouth every 6 hours Take 1 tablet by
mouth every 6 hours
as needed for pain
Triamterene/Hctz - Hydrochlorothiazide: Triamterene 37.5-25mg; 1 tab by mouth once a day blood pressure
Cymbalta - Duloxetine Hydrochloride 60 mg 60 mg Oral CPDR SR Cap,Take 1 capsule by mouth once a day Take 1 capsule by
mouth daily
anti-depressant
Levothyroxine - Levothyroxine Sodium 75 mcg Oral Tab,Take 1 tablet by mouth once a day hypothyroidism
Neurontin - Gabapentin 300 mg Oral Cap,Take 1 capsule by mouth three times a day Take 1 capsule by
mouth 3 times a day
Pantoprazole - Pantoprazole Sodium 20 mg 1 tablet by mouth in the morning 30-60 minutes before a meal for gerd

14. DME and Supplies:

bath bench, commode, cane, rolling walker,

15. Safety Measures:

standard precautions, remove environmental barriers, medication safety, fall precautions, emergency phone number prominently displayed, electrical safety measures, , bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Bowel/Bladder Incontinence, Ambulation

18.B. Activities Permitted

Exercises Prescribed, 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:

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

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Spinal stenosis, lumbar region without neurogenic claudication, 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) assessment completed for a 96-year-old female referred to home health services by her primary care provider due to progressive weakness, decreased mobility, and increased difficulty with ambulation. The patient's past medical history is significant for chronic kidney disease (CKD), hypertension, hypothyroidism, depression, spinal stenosis, hyperlipidemia (HLD), and gastroesophageal reflux disease (GERD). The patient resides with family members in a multi-level home and was previously able to ambulate short distances with a single-point cane (SPC) and longer distances with a rolling walker (RW). During the assessment, the patient reported experiencing intermittent episodes of tremors approximately once per month over the past year. These episodes typically last about one week and significantly impair her ability to ambulate, perform functional tasks, and even feed herself. Since the onset of increased weakness and mobility decline, the patient has demonstrated a notable reduction in functional independence. She currently requires minimal assistance for sit-to-stand transfers and contact guard assistance for ambulation with a rolling walker. Ambulation tolerance is limited to approximately 15 feet due to weakness, decreased endurance, and impaired balance. Physical assessment revealed significant bilateral lower extremity weakness with manual muscle testing (MMT) graded at 2-/5, as well as bilateral upper extremity weakness with MMT graded at 4-/5. The patient demonstrates poor activity tolerance and is only able to participate in therapeutic activities for approximately 30 minutes before requiring rest. She remains a high fall risk secondary to generalized weakness, impaired balance, decreased endurance, and limited mobility. Despite these deficits, the patient is able to perform dressing and bathing tasks independently with setup assistance and utilizes the shower for bathing. The patient's current functional limitations are impacting her safety and independence within the home environment and place her at increased risk for falls and further decline. Skilled physical therapy services are medically necessary to address deficits in strength, balance, endurance, transfer ability, gait, and overall functional mobility. Interventions will focus on lower extremity strengthening, balance training, gait training, transfer training, fall prevention strategies, and patient/caregiver education to improve safety and maximize independence with daily activities. The goal of therapy is to restore the patient to her highest practicable level of function and facilitate a return to her prior level of mobility and independence within the home environment.
 Date of Order 05/26/2026 Orders Physician Face-to-Face Date: 03/02/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat , OT-eval & treat due to Spinal stenosis, lumbar region without neurogenic claudication 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 - PT Notes: soc OT Eval Notes:
 Physician Bullock, Eddye

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/26/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Eddye Bullock
7141 Security Blvd
Baltimore, MD 21244
PHONE: 443-663-6220 FAX: 14436636475 NPI: 1366510703

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 : 03/02/2026

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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SN Careplans

SN Goals

PT Careplans

PT WK1: 1 (05/26/26-05/30/26) ,WK3: 1 (06/07/26-06/13/26) ,WK5: 1 (06/21/26-06/27/26) ,WK7: 1 (07/05/26-07/11/26) ,WK9: 1 (07/19/26-07/24/26)

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, 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170I1 - Walk 10 Feet, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170M1 - 1 - Step (curb), GG0170F1 - Toilet Transfer, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, M1610 - Urinary Incontinence, limited strength, limited range of motion, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

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

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 - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Toilet Transfer - 03. Partial/moderate assistance

1 - Step (curb) - 02. Substantial/maximal assistance

12 Steps - 02. Substantial/maximal assistance

4 Steps - 02. Substantial/maximal assistance

Car Transfer - 04. Supervision or touching assistance

Picking Up Object - 02. Substantial/maximal assistance

Walk 10 Feet - 02. Substantial/maximal assistance

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Walk 150 Feet - 02. Substantial/maximal assistance

Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

Signature of Physician:

Date

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

Date
05/26/2026

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PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, 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, transfers training, teach/coordinate/arrange medication packaging and/or administration

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, * 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 - 04. Supervision or touching assistance, Sit to Stand - 04. Supervision or touching assistance, Toilet Transfer - 03. Partial/moderate assistance, 1 - Step (curb) - 02. Substantial/maximal assistance, 12 Steps - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Car Transfer - 04. Supervision or touching assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

OT Careplans

OT WK1: 1 (05/26/26-05/30/26) ,WK2: 1 (05/31/26-06/06/26) ,WK3: 1 (06/07/26-06/13/26) ,WK4: 1 (06/14/26-06/20/26) ,WK5: 1 (06/21/26-06/27/26) ,WK6: 1 (06/28/26-07/04/26)

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: home exercise program: Home exercise program to constant of using water bottles, dumbbells or theraband for upper extremity., therapeutic exercises: clinician will describe procedure at time of visits, work simplification/energy conservation, transfers training: Transfer

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, Patient will demonstrate improved bilateral upper extremity muscle strength from 4-/5 mmt to 4+/5 mmt to improve ADLs and transfers within 6 wks

OT Goals

PATIENT-STATED GOAL: Patient wants to get stronger and stop falling

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

Patient will demonstrate improved bilateral upper extremity muscle strength from 4-/5 mmt to 4+/5 mmt to improve ADLs and transfers within 6 wks

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/26/2026