Home Health Certification and Plan of Care

Order ID: 1150/19186

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6KJ3UC5PN06	04/07/2026	From: 06/06/2026 To: 08/04/2026	24518	217058

6. Patient's Name and Address
Marilyn Allen
7921 Oakwood Rd,
GLEN BURNIE, MD 21061-
443-763-1254

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 04/06/1953 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
G93.49	Other encephalopathy	04/07/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	04/07/26
F03.93	Unsp dementia unspecified severity with mood disturb	04/07/26
F32.A	Depression unspecified	04/07/26
G89.4	Chronic pain syndrome	04/07/26
N13.2	Hydronephrosis with renal and ureteral calculous obstruction	04/07/26
N13.9	Obstructive and reflux uropathy unspecified	04/07/26
Z79.01	Long term (current) use of anticoagulants	04/07/26
Z86.19	Personal history of other infectious and parasitic diseases	04/07/26

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

ACETAMINOPHEN 325 MG tablet by mouth every 4 hours as needed for Mild Pain.
Dicyclomine HCL 1 capsule 10mg by mouth as necessary Give 1 capsule by mouth every 6 hours as needed for abdominal pain or cramping
MULTIVITAMIN 1 tablet by mouth one time a day for Supplement
MIRALAX 1 packet by mouth as necessary for Constipation prevention
Meclizine Hydrochloride - Meclizine Hydrochloride 25 mg 1 tablet by mouth twice a day Give 1 tablet by mouth every 12 hours as needed for dizziness
Trazodone Hydrochloride - Trazodone Hydrochloride 50 mg 0.5 tablet by mouth at bedtime Give 0.5 tablet by mouth every 24 hours as needed for depression QHS
Sertraline Hcl - Sertraline Hydrochloride 50 mg by mouth once a day Give 1 tablet by mouth one time a day for depression

14. DME and Supplies:
wheelchair, rolling walker, commode, , walker, hospital bed

15. Safety Measures:
wheelchair precautions, standard precautions, fall precautions, avoid temperature extremes, smoke detectors , bedrails up while in bed, supervision at all times, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
broccoli

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Walker, Wheelchair

19. Mental & Pyschosocial Status: COGNITION: 4. Is totally dependent in toileting., ANXIETY: , SOCIAL ISOLATION: , BEHAVIORAL ISSUES: 5-70, HISTORY OF DEPRESSION:

20. Prognosis: poor

22. A Rehabilitation Potential:
SELF-CARE: , MOBILITY:

22.B.Discharge Plans
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Other encephalopathy, 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:

The patient is a 73-year-old female with a significant medical history including kidney stones requiring ureteral stent placement by urology to prevent urinary backflow, recent hospitalization for sepsis secondary to urinary tract infection, arthritis, morbid obesity (approximately 326 lbs), chronic pain, and functional decline. The patient was hospitalized for approximately one and a half weeks about one month ago, followed by a subsequent stay in a nursing facility for an additional one and a half weeks before returning home. She was last seen by her primary care provider last Thursday and has scheduled follow-up appointments for stent removal on April 17, 2026, and a urology evaluation with ultrasound on May 29, 2026. Currently, the patient is bedbound, non-ambulatory, and fully dependent for all activities of daily living and mobility. She reports that she has been unable to ambulate for approximately two years; previously, she was able to independently transfer from bed to bedside commode and wheelchair. However, following her recent hospitalization and rehabilitation stay, she has experienced further functional decline and is now unable to stand, transfer, or ambulate, requiring total assistance including use of a Hoyer lift for transfers. The patient resides in a single-level home with her daughter and son-in-law, who provide continuous caregiving support. On assessment, the patient reports bilateral knee pain related to arthritis and right shoulder pain consistent with a history of rotator cuff injury. Physical findings include decreased strength in bilateral lower extremities, impaired bed mobility requiring full assistance, decreased seated balance at the edge of bed, and increased risk for falls and further functional decline. The patient also has a history of skin breakdown that developed during her recent hospitalization and rehabilitation stay, which has since resolved with residual scarring noted. The patient is considered homebound due to her bedbound status, inability to ambulate, and need for continuous caregiver assistance. She is identified as a high fall and safety risk. The patient's daughter has expressed interest in obtaining home health aide services to assist with care needs. Skilled therapy services are indicated at this time. Physical therapy is recommended to address deficits in strength, balance, transfers, and safety awareness with the goal of improving functional mobility and preventing further decline. Without skilled intervention, the patient remains at high risk for falls, deconditioning, and loss of independence. The planned physical therapy frequency is 1 visit per week for 1 week, followed by 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> per week for 1 week (Monday/Wednesday), then 1 visit per week for 6 weeks (Wednesday). Additionally, occupational therapy services are indicated to address decreased functional activity tolerance, impaired bed mobility, and generalized muscle weakness, with the goal of maximizing independence and preventing further deconditioning. The patient and primary caregivers are in agreement with the established plan of care.
 Date of Order 06/03/2026 Orders Physician Face-to-Face Date: 04/02/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT/OT and Nursing due to Other encephalopathy Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 4 - Recertification Notes: The patient is recertified due to bilateral knee pain, decreased strength in bilateral LEs. She is unable to transfer and requires total assistance for all bed mobility. The patient non ambulatory at this time. The patient is totally dependent in all care, and risk for further functional decline and loss of independence.
 Physician Bolinger, Hannah

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/03/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Hannah Bolinger
7876 W Riverside Dr
Pasadena, MD 21122
PHONE: 4102550102 FAX: 14102550103 NPI: 1417460718

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 : 04/02/2026

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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PT Careplans

PT WK2: 2 (06/07/26-06/13/26) ,WK3: 2 (06/14/26-06/20/26) ,WK4: 2 (06/21/26-06/27/26)

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: WFLs

HOSPITALIZATION RISKS: 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:YES

PROBLEMS IDENTIFIED ON ASSESSMENT: swelling in the arms/legs, abnormal blood pressure, M1033 - Exhaustion, abnormal electrolyte panel, regurgitation of food, muscle weakness, limited strength, limited range of motion, pain radiating to arms/legs, balance deficit, obesity, discolored patches of skin

PROCEDURES: train caregiver(s) to perform medical/rehabilitation treatments: Administration of HEP, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SAQ, hip abd, home exercise program: NA, therapeutic modalities: Apply ice to bilateral knees x 20 minutes with necessary barrier and skin assessments q 5 minutes.

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)

PT Goals

PATIENT-STATED GOAL: To be able to get up and to be able to transfer

GOALS
Roll left & Right - 06. Independent

Sit to Lying - 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

Toilet Transfer - 01. Dependent

Wheel 50 ft w 2 Turns - 01. Dependent

Wheel 150 feet - 01. Dependent

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

Signature of Physician:

Date

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

Date
06/03/2026

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purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, Roll left & Right - 06. Independent, Sit to Lying - 06. Independent, Toilet Transfer - 01. Dependent, Wheel 50 ft w 2 Turns - 01. Dependent, Wheel 150 feet - 01. Dependent

Signature of Physician:	Date
	PAGE 3 of 3
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