Home Health Certification and Plan of Care

Order ID: 1150/19645

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
32269221	06/11/2026	From: 06/11/2026 To: 08/09/2026	26803	217058

6. Patient's Name and Address

Dorothy Brown
4326 Roberton Avenue,
Baltimore, MD 21206-
443-922-1175

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 11/07/1943 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
F03.918	Unsp dementia unsp severity with other behavioral disturb	06/11/26

13. ICD	Other Pertinent Diagnoses	Date
F03.94	Unspecified dementia unspecified severity with anxiety	06/11/26
F03.911	Unspecified dementia unspecified severity with agitation	06/11/26
I10.	Essential (primary) hypertension	06/11/26
E06.3	Autoimmune thyroiditis	06/11/26
E04.2	Nontoxic multinodular goiter	06/11/26
M54.2	Cervicalgia (M54.2)	06/11/26
E66.813	Other obesity	06/11/26
Z68.41	Body mass index [BMI] 40.0-44.9 adult	06/11/26
Z86.718	Personal history of other venous thrombosis and embolism	06/11/26
Z86.711	Personal history of pulmonary embolism	06/11/26
Z79.890	Hormone replacement therapy	06/11/26
Z79.899	Other long term (current) drug therapy	06/11/26
Z96.653	Presence of artificial knee joint bilateral	06/11/26
Z90.710	Acquired absence of both cervix and uterus	06/11/26

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

AMLODIPINE 10 mg = 1 tab by mouth once a day
Cyanocobalamin VITAMIN B12 1,000 mcg = 1 tab by mouth once a day
docusate-senna 50 mg-8.6 mg/tablet / Give 2 tablet by mouth as necessary hold if having more than 2 bowel movements
FOLIC ACID 1 mg = 1 tab by mouth once a day
LEVOTHYROXINE 25 mcg = 1 tab by mouth once a day Take on an empty stomach, 2-4 hours apart from calcium or iron containing vitamins
QUETIAPINE FUMARATE 25 mg/tablet / Give 12.5 mg = 0.5 tab by mouth q24h at 1800
Apresoline - Hydralazine Hydrochloride 1mg by mouth as necessary Anxiety
HYDRALAZINE 100 mg PO 2x/day Blood pressure
Polyethylene Glycol 3350 - Polyethylene Glycol 3350 17 gm PO Daily dissolve in 4 to 8 oz of beverage hold if having more than 2 bowel movements

14. DME and Supplies:

bath bench, cane, walker

15. Safety Measures:

bathroom safety, walker precautions, medication safety, fall precautions

16. Nutrition:

cardiac diet

17. Allergies:

no known allergies

18.A. Functional Limitations

None of the above

18.B. Activities Permitted

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: 8. Patient unable to respond, 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!3. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.!4. Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects), 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 Unspecified dementia, unspecified severity, with other behavioral disturbance, 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 an 82-year-old African American female admitted to home health services following a recent hospitalization and subsequent short-term stays in an assisted care facility and skilled nursing facility for agitation, behavioral disturbances, and altered mental status related to dementia. Her past medical history is significant for dementia with behavioral disturbances, anxiety, hypertension, Hashimoto's thyroiditis, pulmonary embolism, deep vein thrombosis, obesity, prior cervical spine surgery secondary to disc herniation, and other chronic comorbidities. The patient resides with her son in a single-family home and has caregiver support available as needed. Upon arrival for the start-of-care visit, the patient was observed sitting comfortably in her living room. Her son, who was present throughout the visit, reported that she was "having a good day today." The patient was alert and oriented to person, place, and time and demonstrated appropriate cooperation throughout the assessment. She followed directions without difficulty and exhibited no signs of agitation, behavioral disturbances, confusion, or increased anxiety during the visit. Physical assessment revealed lungs clear to auscultation bilaterally and active bowel sounds in all quadrants. The patient reported her last bowel movement occurred the previous evening and denied nausea, vomiting, or other gastrointestinal complaints. Vital signs were obtained, a comprehensive assessment was completed, and medications were reviewed with the patient's son. The patient was formally admitted to home health services following completion of the assessment. The patient lives in a two-story home with six steps required to enter the residence. Her bedroom and bathroom are located on the second floor. Functional assessment revealed that the patient ambulates independently on indoor surfaces without an assistive device for approximately 50 feet on two occasions and is able to negotiate 14 stairs independently using a handrail. She performs transfers to and from the bed, chair, and toilet independently without physical assistance. Prior to hospitalization, the patient was independent with basic self-care activities, functional transfers, and ambulation, and she currently demonstrates functional abilities consistent with her baseline level of performance. During the physical therapy evaluation, the patient declined participation in therapeutic exercises, repeatedly stating that she walks outdoors daily with her son and did not feel additional therapy services were necessary. A home exercise program was issued, and the patient was instructed to perform the exercises daily, ten repetitions each, to maintain strength, flexibility, and overall mobility. Education was also provided regarding the use of a cane for additional support and safety during ambulation when needed. Throughout the evaluation, the patient's son expressed concerns that extensive questioning might increase the patient's anxiety and indicated he was considering discontinuing the therapy session. Despite these concerns, the patient remained calm, cooperative, and appropriately engaged, answering questions without difficulty and exhibiting no observable signs of increased anxiety. Occupational therapy evaluation determined that the patient is functioning at her prior level of independence within the home environment. She is independently completing basic self-care activities, functional transfers, and household ambulation tasks without assistance. No deficits were identified that would warrant ongoing skilled occupational therapy intervention at this time. Likewise, the physical therapy evaluation found the patient to be independent with mobility, transfers, and stair negotiation, with no significant impairments requiring continued skilled therapy services. Therefore, both physical therapy and occupational therapy evaluations were completed as evaluation-only <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh>, and the patient was discharged to self-care with caregiver support and continuation of the prescribed home exercise program. Education regarding home safety, fall prevention, mobility maintenance, and activity participation was provided to the patient

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/11/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Manuel Ramos
1205 York Road Suite 36
Lutherville , MD 21093
PHONE: 4108327350 FAX: 14108327351 NPI: 1427166222

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 : 06/06/2026

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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and caregiver, who verbalized understanding of all instructions.
 Date of Order 06/11/2026 Orders Physician Face-to-Face Date: 06/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Unspecified dementia, unspecified severity, with other behavioral disturbance 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 Ramos, Manuel

SN Careplans

SN WK1: 1 (06/11/26-06/13/26) ,WK2: 1 (06/14/26-06/20/26) ,WK3: 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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 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

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:Not Documented/no existing documents

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M1745 - Behavioral Issues, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, dependent edema, M1400 - Dyspnea

PROCEDURES: cough/deep breathing exercises, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, * 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: Son- "I want more good days like this."

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
* 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
* 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 is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

06/11/2026

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PT WK1: 3 (06/11/26-06/13/26) ,WK2: 3 (06/14/26-06/20/26)

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: home exercise program: Written instructions were issued for supine hip flexion. Bridging, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, 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 - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Car Transfer - 05. Setup or clean-up assistance

PATIENT-STATED GOAL: Be able to walk outside daily

GOALS
Toilet Transfer - 06. Independent

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Car Transfer - 05. Setup or clean-up assistance

OT Careplans

OT WK2: 1 (06/14/26-06/20/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Evaluation only

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

1 - Step (curb) - 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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 03. Partial/moderate 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
06/11/2026