Home Health Certification and Plan of Care

Order ID: 1150/19923

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01266475	06/19/2026	From: 06/19/2026 To: 08/17/2026	19750	217058

6. Patient's Name and Address

Luz Bonilla
4201 Linthicum Road,
DAYTON, MD 21036-
443-546-0118

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 03/12/1938 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
F03.C2	Unspecified dementia severe with psychotic disturbance	06/19/26

13. ICD	Other Pertinent Diagnoses	Date
R62.7	Adult failure to thrive	06/19/26
M25.551	Pain in right hip	06/19/26
M25.561	Pain in right knee	06/19/26
M25.562	Pain in left knee	06/19/26
M19.90	Unspecified osteoarthritis unspecified site	06/19/26
I10.	Essential (primary) hypertension	06/19/26
E53.8	Deficiency of other specified B group vitamins	06/19/26
Z79.891	Long term (current) use of opiate analgesic	06/19/26
Z86.0101	Personal history of adeno	06/19/26
Z91.81	History of falling	06/19/26

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

Latanoprost - Latanoprost 0.005 % ophthalmic solution, Place 1 Drop both eyes at bedtime Place 1 Drop into both eyes nightly, at bedtime
Cosopt - Dorzolamide Hydrochloride: Timolol Maleate 2-0.5 % ophthalmic solution, Place 1 Drop both eyes twice a day
Atenolol - Atenolol 25 MG, Take 1 Tablet (25 mg total) by mouth at bedtime Blood pressure
Pantoprazole - Pantoprazole Sodium 40 MG EC tablet,Take 1 Tablet (40 mg total) by mouth once a day
Acetaminophen - Acetaminophen 325 MG, Take 2 Tablets (650 mg total) by mouth every 6 hours Take 2 Tablets (650 mg total) by mouth every 6 Hours as needed for Pain for up to 30 doses
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 MG, Take 1 Tablet (5 mg total) by mouth every 8 hours Take 1 Tablet (5 mg total) by mouth every 8 hours as needed for Pain Severe for up to 4 days Max Daily Amount: 15 mg
Quetiapine Fumarate - Quetiapine Fumarate 25 MG , Take 1 Tablet (25 mg total) by mouth at bedtime Take 1 Tablet (25 mg total) by mouth nightly, at bedtime
Folic Acid - Folic Acid 1 MG tablet, Take 1 Tablet (1 mg total) by mouth once a day

14. DME and Supplies:

hospital bed, 4 wheeled walker,

15. Safety Measures:

standard precautions, fall precautions, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

iodine penicillins

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Exercises Prescribed, Up As Tolerated, Transfer bed/Chair

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: 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: 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
another facility/provider will be responsible for managing treatment

Homebound status: Due to diagnosis of Unspecified dementia severe with psychotic 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 88-year-old female residing in an assisted living facility with a complex past medical history significant for severe major neurocognitive disorder (advanced dementia), failure to thrive, benign essential hypertension, hyperlipidemia, chronic bilateral knee osteoarthritis with chronic bilateral knee pain, right hip pain, glaucoma, chronic glaucoma, folate deficiency, ataxia, obesity (BMI 32), normocytic anemia, resolved acute kidney injury, history of E. coli urinary tract infection, mild dementia, and a high fall risk. The patient was admitted following a mechanical fall and was referred for skilled home health physical and occupational therapy due to progressive functional decline, impaired mobility, recurrent fall risk, and decreased ability to safely perform activities of daily living. The patient presents with impaired balance, generalized lower extremity weakness, altered gait mechanics, cognitive deficits affecting safety awareness and judgment, decreased activity tolerance, and significant functional limitations. During today's assessment, the patient complained of left shoulder pain and bilateral knee pain. According to the primary caregiver, the patient has become progressively weaker, demonstrates increased agitation, is less cooperative with care, and has been speaking predominantly in Spanish despite previously being fluent in English. The caregiver also reports poor oral intake and inability to independently care for herself. Despite these deficits, the patient was able to ambulate to the restroom using a walker and complete toilet transfer with assistance; however, she requires maximal assistance to dependent assistance for basic activities of daily living, functional mobility, and ambulation, with frequent verbal and tactile cueing for safety, sequencing, and task completion. The patient's impaired cognition, unsteady gait, generalized weakness, pain, and poor endurance substantially increase her risk for falls and injury. The patient is homebound due to advanced cognitive impairment, impaired balance, unsteady gait, high fall risk, generalized weakness, and the need for caregiver assistance to safely leave the residence. Skilled home health physical therapy remains medically

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/19/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Francis Freisinger
655 Watkins Mill Rd
Gaithersberg, MD 20879
PHONE: FAX: NPI: 1669694618

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 : 06/15/2026

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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necessary to provide therapeutic exercises for strengthening, balance training, gait and transfer retraining, functional mobility training, fall prevention interventions, and caregiver education to maximize safety, improve functional mobility, and reduce the risk of further decline and hospitalization. Skilled occupational therapy is also medically necessary to address deficits in activities of daily living, upper extremity function, pain management, adaptive techniques, safety awareness, and caregiver training to improve the patient's functional independence to the greatest extent possible, reduce caregiver burden, and prevent further functional deterioration.
 Date of Order 06/19/2026 Orders Physician Face-to-Face Date: 06/15/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat OT-eval & treat due to Unspecified dementia severe with psychotic 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 - PT Notes: soc OT Eval Notes:
 Physician Freisinger, Francis

SN Careplans

SN Goals

PT Careplans

PT WK1: 1 (06/19/26-06/20/26) ,WK2: 1 (06/21/26-06/27/26) ,WK3: 1 (06/28/26-07/04/26) ,WK4: 1 (07/05/26-07/11/26) ,WK5: 1 (07/12/26-07/18/26) ,WK6: 1 (07/19/26-07/25/26)

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: 1. Non-agency caregiver(s) currently 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:Living Will

PT Goals

PATIENT-STATED GOAL: To walk more around the ALF

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
* 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

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

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

Toilet Transfer - 03. Partial/moderate assistance

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

Car Transfer - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/19/2026

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PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170J1 - Walk 50 ft with 2 Turns, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170I1 - Walk 10 Feet, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, M1745 - Behavioral Issues, M2020 - Oral Med Management, M1400 - Dyspnea, muscle weakness, limited strength

PROCEDURES: B LE mm strengthening: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day., gait training/stair training, transfers training

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, * 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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 03. Partial/moderate assistance, 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

OT Careplans

OT WK2: 1 (06/21/26-06/27/26) ,WK3: 1 (06/28/26-07/04/26) ,WK4: 1 (07/05/26-07/11/26) ,WK5: 1 (07/12/26-07/18/26) ,WK6: 1 (07/19/26-07/25/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating

PROCEDURES: cough/deep breathing exercises, incentive spirometer, home exercise program, 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 - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: TO get able to get around more, eat well stated by ALF staff

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 - 05. Setup or clean-up assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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