Home Health Certification and Plan of Care

Order ID: 1150/20149

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
16310143	06/30/2026	From: 06/30/2026 To: 08/28/2026	27543	217058

6. Patient's Name and Address

Bennie Forrest
532 JAMESTOWN CT,
EDGEWOOD, MD 21040-
4439030673

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 12/08/1942 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M16.0	Bilateral primary osteoarthritis of hip	06/30/26

13. ICD	Other Pertinent Diagnoses	Date
M19.011	Primary osteoarthritis right shoulder	06/30/26
I10.	Essential (primary) hypertension	06/30/26
E11.9	Type 2 diabetes mellitus without complications	06/30/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	06/30/26
E78.00	Pure hypercholesterolemia unspecified	06/30/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	06/30/26
G30.9	Alzheimer's disease unspecified	06/30/26
F02.80	Dem in oth dis classd elswhrunsp sevw/o beh/psych/mood/anx	06/30/26
F22.	Delusional disorders	06/30/26
M51.16	Intervertebral disc disorders w radiculopathy lumbar region	06/30/26
R73.03	Prediabetes	06/30/26
G89.4	Chronic pain syndrome	06/30/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/30/26
I89.0	Lymphedema not elsewhere classified	06/30/26
H91.92	Unspecified hearing loss left ear	06/30/26
E66.01	Morbid (severe) obesity due to excess calories	06/30/26
Z68.36	Body mass index [BMI] 36.0-36.9 adult	06/30/26
Z79.01	Long term (current) use of anticoagulants	06/30/26
Z86.711	Personal history of pulmonary embolism	06/30/26
Z96.652	Presence of left artificial knee joint	06/30/26
Z96.1	Presence of intraocular lens	06/30/26
Z91.81	History of falling	06/30/26

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

SERTRALINE Take 100 MG Tablet by mouth daily
Multivitamin Womens 50+ Adv 0 Take 1 tablet by mouth in the morning
Metoprolol Tartrate - Metoprolol Tartrate Take 50 MG Tablet by mouth 2 times daily
LOSARTAN POTASSIUM Take 100 MG Tablet by mouth daily
GABAPENTIN 300 MG / 1 Capsule by mouth once a day and 2 capsules at night
FUROSEMIDE Take 20 MG Tablet by mouth every 48 hours
ACETAMINOPHEN Take 500 mg tablet by mouth 2 times daily as needed for Pain
ATORVASTATIN 40 MG / 1 Tablet by mouth daily
CALCIUM-VITAMIN D PO 1 tablet by mouth 2 times daily
DABIGATRAN ETEXILATE Take 150 MG Capsule by mouth 2 times daily
FAMOTIDINE 20 MG / 1 Tablet by mouth daily
Refresh Soln ophthalmic solution 1.4-0.6 % / Apply 1 drop to eye drops as necessary 3 times daily
Diclofenac Sodium - Diclofenac Sodium 1 % Gel / Apply 4 g to left hip, both knees, lower back, both shoulders. skin 2 times daily Do not apply external heat or occlusive dressings to application site; avoid wearing clothes or gloves for at least 10 minutes after application

14. DME and Supplies:

walker, , , reacher, hospital bed, bath bench

15. Safety Measures:

walker precautions, , standard precautions, medication safety, knee precautions, hip precautions, fall precautions, bleeding precautions, bathroom safety, anticoagulant precautions, ambulates with device

16. Nutrition:

low sodium

17. Allergies:

penicillins octacosanol tbhq

18.A. Functional Limitations

Ambulation,!Paralysis

18.B. Activities Permitted

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: 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!6. Delusional, hallucinatory, or paranoid behavior, 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

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Bilateral primary osteoarthritis of hip, 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 83-year-old female with a significant past medical history of gastroesophageal reflux disease (GERD), hypertension, hyperlipidemia, coronary artery disease (CAD), dementia, delusional disorder, pre-diabetes, osteoarthritis involving multiple sites, and a history of recurrent falls, placing her at high risk for future falls. She was recently hospitalized after slipping out of bed and sustaining an injury that resulted in severe left hip and left leg pain with an inability to bear weight. Since returning home, the patient has experienced a significant decline in her functional status, with profound generalized weakness and inability to safely get out of bed without extensive assistance. The patient resides with family in a single-family home, where her daughter serves as the primary caregiver. Upon skilled nursing assessment, the patient was alert and oriented to person, place, time, and situation. She reported generalized pain rated 10/10, predominantly localized to the left hip and left leg. A message was left with the primary care provider requesting evaluation and appropriate pain management, as the patient received oxycodone during hospitalization but was discharged without a prescription for pain medication. The patient's daughter attempted to assist her with transferring out of bed; however, due to significant weakness, the patient required the assistance of two individuals to safely return to bed. Although she was able to reposition herself in bed, she consistently favored her left side because of pain and discomfort. Assessment revealed warm, intact skin overall, with dry, cracked skin noted on the left elbow. The caregiver was instructed to apply moisturizer regularly to maintain skin integrity and prevent further breakdown. Bilateral lower extremity edema was also observed, and the patient and family were educated on the importance of elevating the legs to assist with

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/30/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Stephanie Davis
3400 Box Hill Corporate Center Dr
Abingdon, MD 21009
PHONE: 1-800-777-7904 FAX: kaiser NPI: 1013976091

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 : 06/26/2026

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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edema management. No additional areas of skin breakdown were noted. Medication reconciliation was completed, and education was provided regarding medication adherence, infection prevention strategies, recognition and reporting of changes in condition, fall prevention measures, and the importance of caregiver participation while utilizing available support systems to reduce caregiver strain. Due to the patient's marked weakness, limited mobility, dependence with activities of daily living, and increased fall risk, home health aide (HHA) services are recommended to assist with personal care and promote safety within the home environment. An occupational therapy evaluation was also completed following hospitalization secondary to the recent fall. Prior to hospitalization, the patient was independent with basic self-care activities, functional transfers, and household ambulation using a rolling walker, requiring only supervision from her granddaughter during bathing. Since hospitalization, the patient has experienced a substantial decline in functional performance. Assessment revealed decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, decreased activity tolerance, and impaired functional mobility, all of which significantly limit her independence with self-care tasks, functional transfers, and ambulation. Skilled occupational therapy services are medically necessary to address these deficits through therapeutic exercise, balance and endurance training, transfer training, activities of daily living retraining, safety education, caregiver instruction, and adaptive strategies with the goal of maximizing functional independence, reducing fall risk, and facilitating the patient's return to her highest achievable level of function within the home environment.
 Date of Order 06/30/2026 Orders Physician Face-to-Face Date: 06/26/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Bilateral primary osteoarthritis of hip 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 OT Eval Notes:
 Physician Davis, Stephanie

SN Careplans

SN WK1: 1 (06/30/26-07/04/26) ,WK2: 1 (07/05/26-07/11/26) ,WK3: 1 (07/12/26-07/18/26) ,WK4: 1 (07/19/26-07/25/26) ,WK5: 1 (07/26/26-08/01/26) ,WK6: 1 (08/02/26-08/08/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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:REFUSED

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M2020 - Oral Med Management, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, frequent urination, limited strength, muscle weakness, balance deficit, Pain Interference with ADLs

PROCEDURES: coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion

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

SN Goals

PATIENT-STATED GOAL: To be able to walk with an assistive device

GOALS
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
* 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/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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/30/2026

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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, * 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, * 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

OT Careplans

OT WK1: 1 (06/30/26-07/04/26) ,WK3: 1 (07/12/26-07/18/26) ,WK5: 1 (07/26/26-08/01/26) ,WK7: 1 (08/09/26-08/15/26) ,WK9: 1 (08/23/26-08/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0170P1 - Picking Up Object, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Medication Review : Medication reviewed with patient with all medications in the home, home exercise program: Bilateral UE strengthening- biceps curls, armchair press-ups, pectoral stretches. All exercises 2-3 sets 8-12 reps, equipment training, work simplification/energy conservation, transfers training: Skilled OT, assist with bathing: Skilled OT, assist with toilet transferring: Skilled OT, assist with lower body dressing: Skilled OT

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 - 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: Get up the stairs

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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 - 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

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/30/2026