Home Health Certification and Plan of Care

Order ID: 1150/20154

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
87309431	07/01/2026	From: 07/01/2026 To: 08/29/2026	27611	217058

6. Patient's Name and Address
Othen Buie
417 7th Avenue,
GLEN BURNIE, MD 21060-
240-234-1152

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 05/19/1943 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M17.0	Bilateral primary osteoarthritis of knee	07/01/26

13. ICD	Other Pertinent Diagnoses	Date
M19.041	Primary osteoarthritis right hand	07/01/26
M19.042	Primary osteoarthritis left hand	07/01/26
F03.B18	Unsp dementia moderate with other behavioral disturb	07/01/26
F32.A	Depression unspecified	07/01/26
I11.0	Hypertensive heart disease with heart failure	07/01/26
I50.32	Chronic diastolic (congestive) heart failure	07/01/26
Z79.82	Long term (current) use of aspirin	07/01/26

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

LIPITOR eq 80 mg base 80 MG / 1 Tablet by mouth daily for cholesterol and heart protection cholesterol
ARICEPT 5 mg 5 MG / 1 Tablet by mouth daily dementia
ZOLOFT eq 50 mg base 50 MG / 1 Tablet by mouth daily depression
NORVASC eq 10 mg base 10 MG / 1 Tablet by mouth daily blood pressure
LASIX 20 mg 20 MG / 1 Tablet by mouth every morning fluid pill
MOBIC 7.5 mg/tablet / Take 2 tablets by mouth once a day for next 1 week, followed by once a day as needed only. arthritis
CYMBALTA 30 mg SR 60 MG / 1 Capsule by mouth daily depression
Tylenol Es - Acetaminophen 500mg; 1 tab by mouth twice a day pain
Doxylamine Succinate - Doxylamine Succinate 25 mg 25mg; 1 tab by mouth as necessary for insomnia

14. DME and Supplies:
hand held shower, bath bench

15. Safety Measures:
standard precautions, fall precautions, medication safety, supervision at all times, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: 4. Constantly, 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: Yes

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 Bilateral primary osteoarthritis of knee, 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 84-year-old female with a primary diagnosis of dementia with subacute cognitive and balance changes. Her past medical history is significant for bilateral knee osteoarthritis, essential hypertension, depression, chronic hand arthritis, and impaired balance with cognitive decline. The patient remains homebound due to dementia, impaired safety awareness, cognitive deficits, decreased balance, and high fall risk, requiring human assistance to safely leave the home. Skilled nursing services are ordered at a frequency of 1 visit weekly for 12 weeks, followed by 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> weekly for 1 week, then 1 visit weekly for 6 weeks. Physical and occupational therapy evaluations were completed and skilled therapy services were recommended. The patient resides in a single-level home with four steps at the entrance. She receives extensive assistance from her neighbor and primary caregiver, Mary, who manages all medications and assists with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). An additional caregiver, Rena, provides evening assistance with grocery shopping, housekeeping, and other household tasks. The patient ambulates within the home without an assistive device; however, according to her caregiver, she has a history of wandering due to cognitive impairment, requiring close supervision for safety. She has experienced a recent fall within the home, further increasing her risk for injury. During the skilled nursing assessment, the patient was alert and oriented to person and place, requiring frequent reorientation to time. She denied shortness of breath, and lung sounds were clear throughout with respirations even and unlabored. She reported a good appetite and normal bowel function, with her last bowel movement occurring on the day of assessment. Assessment revealed +1 bilateral lower extremity edema, greater on the right than the left. The patient reported chronic bilateral knee pain, more pronounced in the right knee during this visit, status post cortisone injection approximately one month ago. She manages pain with Tylenol 500 mg twice daily with partial relief. She also reported chronic left knee pain characterized by intermittent sharp, pinching sensations upon standing in the morning, as well as bilateral hand pain related to arthritis, resulting in difficulty grasping and manipulating objects. The patient additionally experiences urinary frequency without dysuria or burning and reports intermittent visual hallucinations associated with dementia. According to the caregiver, cognitive decline has progressively worsened over recent weeks, with increasing forgetfulness, confusion, impaired memory, and episodes of not recognizing familiar situations despite maintaining adequate eating, drinking, and sleeping habits. Medication reconciliation was completed, and all medications, dosages, administration schedules, intended purposes, and potential side effects were reviewed with the caregiver, who demonstrated understanding and continues to manage medication administration. Skilled nursing provided education regarding effective pain management strategies, edema management including lower extremity elevation, medication compliance, fall prevention, home safety measures, and ongoing supervision related to the patient's cognitive impairment and wandering behaviors. Both the patient and caregiver were receptive to all teaching provided. Physical therapy evaluation identified bilateral lower extremity weakness, decreased functional mobility, impaired transfers, unsteady gait, decreased balance, impaired safety awareness, difficulty negotiating stairs, chronic bilateral knee pain, and a significantly increased risk for falls. These deficits substantially impair the patient's mobility and independence within the home. Skilled physical therapy is medically necessary to improve lower extremity strength, gait quality, balance, transfer safety, stair negotiation, functional mobility, and overall safety awareness in order to reduce fall risk, prevent further functional decline, and maximize independence within the home environment. The patient and caregiver are in agreement with the established physical therapy plan of care. Occupational therapy evaluation further identified decreased cognitive function, impaired memory, reduced upper extremity and hand function secondary to arthritis, decreased activity tolerance, impaired balance, diminished safety awareness, and difficulty performing activities of daily living independently. The patient demonstrated hearing impairment but remained cooperative throughout the evaluation, followed directions appropriately, and actively participated in prescribed therapeutic exercises despite requiring frequent cueing due to cognitive deficits. Skilled occupational therapy is medically necessary to improve upper extremity strength, hand function, coordination, functional independence with self-care tasks, home safety, cognitive compensation strategies, and overall quality of life while reducing caregiver burden and supporting the patient's ability to safely remain in her home.
 Date of Order 07/01/2026 Orders Physician Face-to-Face Date: 04/24/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Bilateral primary osteoarthritis of knee Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/01/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Umme Yasmin
7670 Quaterfield Rd
Pasadena, MD 21122
PHONE: 410-508-7650 FAX: 1-410-553-2465 NPI: 1164702874

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 : 04/24/2026

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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home
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Yasmin, Umme

SN Careplans

SN WK1: 1 (07/01/26-07/04/26) ,WK2: 2 (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) ,WK7: 1 (08/09/26-08/15/26)

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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, D0160 - Depression, M1745 - Behavioral Issues, M2020 - Oral Med Management, meal preparation, dependent edema, M1400 - Dyspnea, limited range of motion, limited strength, limited endurance, balance deficit, Pain Effect on Sleep, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises, 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 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, * how to keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: TO GET STRONGER AND FOR LEG SWELLING TO DECREASE

GOALS
patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* 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
* 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
* 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

meal preparation is available to patient for all meals

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

07/01/2026

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PT WK1: 1 (07/01/26-07/04/26) ,WK2: 2 (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) ,WK7: 1 (08/09/26-08/15/26) ,WK8: 1 (08/16/26-08/22/26) ,WK9: 1 (08/23/26-08/29/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car 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, GG0170E1 - Chair to Bed to Chair

PROCEDURES: home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention: Pt/PCG teaching on Falls prevention -use recomended AD at all times and/or direct assistance by CG as needed -make sure clothing does not drag on floor to create trip hazard -proper footwear, no scuffs - Strength program has been initiated for LEs, continue 1-2x/day -carry phone at all times in case of emergency -Consider medic alert button -Fall recover technique discussed -Keep stairs free of obstacles -Maintain functional pathways throughout the home and at all exits -use night lights -Advised against holding onto towel bars or soap dishes, consider grab bars, check grab bars before use -remove scatter rugs, if one must remain use double sided rug tape -Add non skid mat in the shower -keep the floor dry in the bathroom, if using a shower seat dry self completely before stepping out.

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car 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

PATIENT-STATED GOAL: To improve strength

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car 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

OT Careplans

OT WK1: 1 (07/01/26-07/04/26) ,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) ,WK7: 1 (08/09/26-08/15/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: cough/deep breathing exercises, incentive spirometer, home exercise program: Exe prescribed for strengthing ms of shoulder, elbow and wrist, 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: CG wants Pt to be more independent

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/01/2026