Home Health Certification and Plan of Care

Order ID: 1150/20566

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
591016388	07/14/2026	From: 07/14/2026 To: 09/11/2026	28072	217058

6. Patient's Name and Address
Bonnie Cromer
3 Bristol Hill Court Apt B2,
Catonsville, MD 21228-
443-514-9489

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 06/23/1951 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I10.	Essential (primary) hypertension	07/14/26

13. ICD	Other Pertinent Diagnoses	Date
I70.0	Atherosclerosis of aorta	07/14/26
S20.20XD	Contusion of thorax unspecified subsequent encounter	07/14/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	07/14/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	07/14/26
Z79.890	Hormone replacement therapy	07/14/26
Z91.81	History of falling	07/14/26

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

AMBIEN 5 MG / 1 Tablet by mouth at bedtime as needed for sleep
LOPRESSOR 50 mg 50 MG / 1 Tablet by mouth 2 times a day with meals For high blood pressure High blood pressure
Glucophage Xr - Metformin Hydrochloride SR 500 MG / 1 Tablet by mouth every evening with a meal for diabetes DM
REMERON 7.5 MG / 1 Tablet by mouth daily at bedtime Depression
Zestril - Lisinopril 40 MG / 1 Tablet by mouth daily For high blood pressure
PLAVIX eq 75 mg base 75 MG / 1 Tablet by mouth daily Blood thinner
Synthroid - Levothyroxine Sodium 150 MCG / 1 Tablet by mouth in the morning 30 minutes before a meal for thyroid
LIPITOR eq 80 mg base 80 MG / 1 Tablet by mouth daily For cholesterol
APRESOLINE 50 MG / 1 Tablet by mouth 3 times a day with meals For high blood pressure
Effexor Xr - Venlafaxine Hydrochloride SR 150 MG / 1 Capsule by mouth daily For anxiety
Cetirizine Hydrochloride - Cetirizine Hydrochloride 10 mg 1 tablet by mouth once a day As needed for allergies
Albuterol - Albuterol 0.09 mg/inh 2 puffs inhalant every 4 hours As needed for breathing

14. DME and Supplies:
rolling walker, , cane, bath bench

15. Safety Measures:
standard precautions, remove environmental barriers, , medication safety, fall precautions, electrical safety measures, emergency phone number prominently displayed, diabetic precautions, bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
penicillin trazodone wellbutrin

18.A. Functional Limitations
Ambulation, Endurance!Bowel/Bladder Incontinence

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: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: Good

22. A Rehabilitation Potential:
SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

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

Homebound status: Due to diagnosis of Essential (primary) hypertension, 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 75-year-old female with a past medical history significant for hypertension, diabetes mellitus, and hyperlipidemia who was recently hospitalized following a mechanical fall resulting in right flank pain with left flank and chest wall contusions. Prior to hospitalization, the patient was ambulatory with a rolling walker under supervision; however, she has experienced multiple recent falls and has also been coping with depression and insomnia following the death of her husband several months ago. She currently resides in an apartment with her son, who provides assistance as needed. A comprehensive physical therapy start of care evaluation was completed. Assessment revealed generalized functional decline with bilateral lower extremity weakness, demonstrating manual muscle testing of 3-/5, and bilateral upper extremity weakness with muscle strength of 4/5. The patient requires moderate assistance for transfers and contact guard assistance for sit-to-stand and toilet transfers, requiring frequent verbal cueing for appropriate hand and lower extremity placement to ensure safety. She ambulates short distances using a rolling walker with minimal assistance and requires verbal cues to maintain upright trunk posture and improve gait mechanics. For activities of daily living, the patient requires standby assistance for bathing and dressing tasks while seated due to decreased strength, impaired balance, and reduced activity tolerance. Although the patient previously used a cane for ambulation, her recent decline in mobility and recurrent falls indicate the need for a rolling walker to maximize stability and safety. The patient's impairments in strength, balance, transfer ability, gait, and overall functional mobility place her at an increased risk for additional falls and limit her ability to safely perform daily activities independently. Skilled physical therapy is medically necessary to improve lower extremity strength, balance, gait quality, transfer safety, endurance, and overall functional mobility while reducing fall risk and maximizing independence. Education was provided regarding fall prevention strategies, proper use of assistive devices, transfer techniques, posture correction during ambulation, and home safety. Continued skilled physical therapy interventions are indicated to restore the patient's prior level of function, improve safety within the home environment, and decrease caregiver burden while promoting the highest attainable level of independence.
 Date of Order 07/14/2026 Orders Physician Face-to-Face Date: 07/11/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat OT-eval & treat due to Essential (primary) hypertension 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 Hamilton, Abigail

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/14/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Abigail Hamilton
1701 Twin Springs Rd
Halthorpe, MD 21227
PHONE: 410-737-5000 FAX: 14107375401 NPI: 1821592817

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 : 07/11/2026

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 WK1: 1 (07/14/26-07/18/26) ,WK3: 1 (07/26/26-08/01/26) ,WK5: 1 (08/09/26-08/15/26) ,WK7: 1 (08/23/26-08/29/26) ,WK9: 1 (09/06/26-09/11/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170L1 - Walk 10 ft on Uneven Surface, GG0170I1 - Walk 10 Feet, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, D0160 - Depression, M2020 - Oral Med Management, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, M1033 - Exhaustion, M1610 - Urinary Incontinence, limited strength, limited endurance, difficulty sleeping, Pain Interference with ADLs, Pain Interference with Therapy activities, balance deficit, lethargy

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, home exercise program; Review HEP: seated knee ext

PT Goals

PATIENT-STATED GOAL: To be able to walk without help

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

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

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

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

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

Toilet Transfer - 01. Dependent

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

Oral Hygiene - 03. Partial/moderate assistance

Toileting Hygiene - 03. Partial/moderate assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Upper Body Dressing - 03. Partial/moderate assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 06. Independent

Signature of Physician:

Date

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

Date
07/14/2026

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medical/rehabilitation treatments, home exercise program. Review HEP : seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed. Upgrade as tolerated, equipment training, gait training/stair training, transfers training, teach/coordinate/arrange medication packaging and/or administration

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, * 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, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 01. Dependent, 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, Oral Hygiene - 03. Partial/moderate assistance, Toileting Hygiene - 03. Partial/moderate assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 03. Partial/moderate assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent

OT Careplans

OT WK2: 1 (07/19/26-07/25/26) ,WK4: 1 (08/02/26-08/08/26) ,WK6: 1 (08/16/26-08/22/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, 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

PROCEDURES: Transfer training: Sit to stand transfer and toliet transfers, Functional ambulation : Cane or rolling walker, Patient/caregiver recalls related purpose and schedule of medications: Medication Review, cough/deep breathing exercises, therapeutic exercises: Using dumbbells or therabands to perform bilateral upper extremity muscle strength exercises

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 - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent, Patient will demonstrates improved left upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve Adls and transfers safely

OT Goals

PATIENT-STATED GOAL: Patient wants to get stronger

GOALS
Shower/Bathe Self - 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

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 - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Patient will demonstrates improved left upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve Adls and transfers safely

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/14/2026