Home Health Certification and Plan of Care

Order ID: 1150/20915

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
13310295	07/28/2026	From: 07/28/2026 To: 09/25/2026	28486	217058

6. Patient's Name and Address

Lorraine Hope
2303 Round Road Apt T4,
Baltimore, MD 21225-
410-952-1072

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 04/20/1957 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I21.3	ST elevation (STEMI) myocardial infarction of unsp site	07/28/26

13. ICD	Other Pertinent Diagnoses	Date
I69.351	Hemiplga following cerebral infrc aff right dominant side	07/28/26
I48.20	Chronic atrial fibrillation unspecified	07/28/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	07/28/26
I50.30	Unspecified diastolic (congestive) heart failure	07/28/26
N18.32	Chronic kidney disease stage 3b	07/28/26
J44.9	Chronic obstructive pulmonary disease unspecified	07/28/26
E78.5	Hyperlipidemia unspecified	07/28/26
Z79.01	Long term (current) use of anticoagulants	07/28/26
Z87.891	Personal history of nicotine dependence	07/28/26

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

fluticasone-salmeterol 100-50 MCG/ACT inhaler 1 puff by inhalation 2 times daily
ALBUTEROL 108 (90 BASE) mcg/act aerosol solution / 1 puff by inhalation every 4 hours as needed for Wheezing
LISINOPRIL 40 mg/tablet / Take 0.5 tablet by mouth daily
AMLODIPINE 10 MG / 1 Tablet by mouth daily
ATORVASTATIN 80 MG tablet by mouth daily
DABIGATRAN ETEXILATE 150 MG capsule by mouth 2 times daily
FUROSEMIDE 20 MG tablet by mouth daily
SERTRALINE 50 MG / 1 Tablet by mouth daily
NITROGLYCERIN 0.4 MG Tablet / Place 1 tablet under the tongue every 5 min as needed for Chest Pain maximum 3 tablets every 5 minutes with chest pain.

14. DME and Supplies:

rolling walker

15. Safety Measures:

transfer with assist, fall precautions, avoid temperature extremes, ambulates with device, standard precautions, emergency phone number prominently displayed, ambulates with assistance, smoke detectors , medication safety, cardiac precautions, bathroom safety, activity supervision

16. Nutrition:

low sodium

17. Allergies:

no known allergies

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Ambulation

18.B. Activities Permitted

Cane, Exercises Prescribed, Walker, Transfer bed/Chair, 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: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

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

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of St elevation (stemi) myocardial infarction of unspecified site, 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 69-year-old female admitted to home health services for physical therapy following hospitalization at BWMC from 07/21/2026 to 07/23/2026 for an acute myocardial infarction. During hospitalization, the patient tested positive for fentanyl and benzodiazepines. Her past medical history is significant for atrial fibrillation managed with dabigatran, prior cerebrovascular accidents with residual right-sided weakness, recent acute ischemic stroke (hospitalized and discharged on 07/09/2026), chronic obstructive pulmonary disease (COPD), myocardial infarction, hypertension, hyperlipidemia, and a history of substance use. The patient presented to the hospital with intermittent central chest tightness associated with shortness of breath, without radiation, nausea, vomiting, diaphoresis, or lower extremity swelling. Symptoms resolved prior to evaluation. Cardiac catheterization was performed during hospitalization, after which she required supplemental oxygen at 2 L/min due to oxygen saturations in the high 80s; however, she did not require home oxygen prior to admission. The patient reports she quit smoking and discontinued illicit drug use approximately three weeks prior to hospitalization. Current medications include dabigatran 150 mg twice daily, metoprolol succinate 50 mg daily, amlodipine 10 mg daily, lisinopril 40 mg daily, furosemide 20 mg daily, atorvastatin 80 mg daily, Wixela inhaler one puff twice daily, and albuterol inhaler as needed. Medication reconciliation was completed with no significant discrepancies identified. The patient returned home with continuous assistance from family caregivers and currently resides with her son and his family. Her daughter-in-law also assists with caregiving when available. She ambulates with a front-wheeled walker and occasionally uses a cane for household mobility. The home environment includes two steps at the front entrance and an additional five steps leading to the apartment, creating barriers to safe mobility. The patient reports experiencing four to five falls within the past year and demonstrates decreased safety awareness, placing her at significant risk for future falls. She is currently able to perform basic activities of daily living with standby to minimal assistance and requires supervision for indoor mobility. She reports bilateral lower extremity arthritic pain, decreased lower extremity strength, impaired balance, decreased endurance, unsteady gait, difficulty negotiating stairs, impaired transfers, and reduced functional mobility. Additionally, she reports blurred vision and bilateral hand numbness and tingling. The patient also stated that a recent angiogram was performed through the right upper extremity. A comprehensive home safety assessment was completed, informed consents were obtained, and the patient handbook was reviewed. The patient and caregiver participated in the development of the physical therapy plan of care and verbalized agreement with the proposed treatment plan. Home safety education focused on fall prevention strategies, identification of fall risk factors, and environmental modifications to reduce the likelihood of injury. Transfer training was initiated using a front-wheeled walker, with instruction emphasizing proper hand and foot placement, forward weight shifting during sit-to-stand, and reaching back to the chair before sitting. The patient required standby assistance with verbal cueing to safely complete transfers. Gait training was performed on level surfaces using the walker, during which the patient required standby assistance and verbal cues to maintain appropriate positioning within the walker, improve bilateral step height and step length, and maximize overall safety. Standardized balance and mobility assessments, including the Tinetti Balance Assessment and Timed Up and Go (TUG) test, were completed. The patient was instructed to use her walker at all times during ambulation to reduce fall risk. The patient was educated regarding the importance of daily ambulation to improve circulation, maintain strength, and prevent complications associated with prolonged inactivity. She was instructed to begin a walking program consisting of short walks every one to two hours throughout the day, gradually progressing to continuous walks of three to five minutes as tolerated. Pain was reported to be well controlled with the current medication regimen. Education was provided regarding effective pain management, including taking pain medication at the onset of discomfort, recognizing potential medication side effects such as dizziness and constipation, and seeking immediate medical attention by calling 911 or notifying the healthcare provider for chest pain, unrelieved pain, or shortness of breath. The patient was also advised to take prescribed pain medication approximately one hour prior to physical therapy visits to optimize participation. The patient demonstrated understanding of all education provided through the teach-back method. The patient additionally demonstrates deficits appropriate for skilled occupational therapy, including impaired upper extremity strength, decreased activity tolerance, impaired functional endurance, and reduced independence with daily functional tasks secondary to her recent cardiac event, prior strokes, and generalized deconditioning. Skilled occupational therapy services are medically necessary to improve upper extremity strength, increase activity

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/28/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Kenetra Hix
3510 Brenbrook Dr
Randallstown, 0 21133
PHONE: 4107375000 FAX: 899290091 NPI: 1972917979

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 : 07/23/2026

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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tolerance, enhance performance of activities of daily living, and maximize functional independence and safety within the home environment. The patient remains homebound due to significant functional limitations, impaired balance, history of multiple falls, residual neurological deficits, decreased strength, and dependence on a walker with human assistance to safely leave the home. Skilled physical and occupational therapy services are medically necessary to address deficits in strength, balance, gait, transfers, stair negotiation, endurance, safety awareness, and functional mobility in order to reduce fall risk, prevent further functional decline and rehospitalization, and restore the patient's highest achievable level of independence. Physical therapy services are scheduled to begin on 07/28/2026 at a frequency of two visits per week for two weeks followed by one visit per week for four weeks, with follow-up scheduled with Dr. Kenetra Hix on 08/04/2026. The referring physician has been notified of the patient's admission to home health services.
 Date of Order 07/28/2026 Orders Physician Face-to-Face Date: 07/23/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat, OT-eval & treat due to St elevation (stemi) myocardial infarction of unspecified site 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 Hix, Kenetra

SN Careplans

SN Goals

PT Careplans

PT WK1: 2 (07/28/26-08/01/26) ,WK2: 2 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26) ,WK6: 1 (08/30/26-09/05/26)

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), 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 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, 9. Other risk(s) not listed in 1- 8

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,

PT Goals

PATIENT-STATED GOAL: I want to be able to walk independently

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Shower/Bathe Self - 05. Setup or clean-up assistance

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

patient living environment has safe floor coverings

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
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dose, interactions of all new/change meds
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170P1 - Picking Up Object, 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, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, Home Safety, M2020 - Oral Med Management, lightheadedness, M1400 - Dyspnea, M1033 - Exhaustion, limited endurance, muscle weakness, Pain Interference with ADLs, difficulty sleeping

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., work simplification/energy conservation, 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/stair training, transfers training, assist with fall prevention, coordinate/arrange repair of unsafe floor coverings

TEACH PATIENT/CAREGIVER: * 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, patient living environment has safe floor coverings, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, Sit to Stand - 06. Independent, Chair to Bed to Chair - 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, 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 - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

4 Steps - 04. Supervision or touching assistance

Eating - 06. Independent

OT Careplans

OT WK1: 1 (07/28/26-08/01/26) ,WK2: 1 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26) ,WK6: 1 (08/30/26-09/05/26)

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: Medication review : med updates, Improve UE strength : to 4, Improve activity tolerance: TO be able to do any acitivy in sitting and standing for 5 mins wihtout breaks, cough/deep breathing exercises, incentive spirometer, home exercise program: exercises for shoulder, elbow and wirst, 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 - 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: I want to be able to do things for myself

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 - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Eating - 06. Independent

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