

Home Health Certification and Plan of Care				Order ID: 1150/20926					
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period		4. Medical Record No.		5. Provider No.	
10003613		07/27/2026		From: 07/27/2026 To: 09/24/2026		28320		217058	
6. Patient's Name and Address Lucy DeHaven 327 Lord Byron Lane Apt 102, COCKEYSVILLE, MD 21030 410-919-3532					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 12/28/1937 9.Sex Female					10. Medications: Dose/Frequency/Route (N)ew (C)hanged Aspirin-Dipyridamole Extended Release 12 Hour 25-200 MG / 1 Capsule by mouth twice a day for DVT Metoprolol Tartrate - Metoprolol Tartrate 100 MG / 1 Tablet by mouth two times a day for Hypertension Hold for SBP less than 110 or HR less than 60 Milk Of Magnesia - Simethicone Suspension Give 30 ml by mouth every 24 hours as needed for constipation NIFEDIPINE Extended Release 60 MG / 1 Tablet by mouth one time a day for HTN Hold for SBP less than 110 or HR less than 60 OMEPRAZOLE Delayed Release 40 MG / 1 Capsule by mouth one time a day for GERD SIMVASTATIN 40 MG / 1 Tablet by mouth one time a day for HLD SUCRALFATE 1 GM / 1 Tablet by mouth with meals for GERD for 21 Days Sodium Chloride - Sodium Chloride 1 GM / 1 Tablet by mouth once a day for SIADH REFRESH TEARS Ophthalmic Solution / Instill 1 drop in both eyes three times a day for dry eyes Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 200-62.5-25 MCG/ACT (Fluticasone-Umeclidinium-Vilanterol) 1 puff inhale orally one time a day for Asthma Albuterol Sulfate - Albuterol Sulfate HFA 108 (90 Base) MCG/ACT Aerosol Solution / 2 puff inhale orally every 6 hours as needed for Asthma/SOB/Wheezing				
11. ICD J15.4			Principal Diagnosis Pneumonia due to other streptococci			Date 07/27/26			
13. ICD J45.909 E87.1 I11.0 I50.32 E78.49 I25.10 I27.20 K21.9 M19.90 Z86.73 Z99.81 Z79.51 Z79.82 Z95.2 Z86.19			Other Pertinent Diagnoses Unspecified asthma uncomplicated Hypo-osmolality and hyponatremia Hypertensive heart disease with heart failure Chronic diastolic (congestive) heart failure Other hyperlipidemia Athscl heart disease of native coronary artery w/o ang pctrs Pulmonary hypertension unspecified Gastro-esophageal reflux disease without esophagitis Unspecified osteoarthritis unspecified site Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits Dependence on supplemental oxygen Long term (current) use of inhaled steroids Long term (current) use of aspirin Presence of prosthetic heart valve Personal history of other infectious and parasitic diseases			Date 07/27/26 07/27/26 07/27/26 07/27/26 07/27/26 07/27/26 07/27/26 07/27/26 07/27/26 07/27/26 07/27/26 07/27/26 07/27/26 07/27/26			
14. DME and Supplies: cane, rolling walker, bath bench, commode					15. Safety Measures: supervision at all times, standard precautions, ambulates with device, ambulates with assistance, activity supervision				
16. Nutrition: Z. NO PHYSICIAN-ORDERED DIET					17. Allergies: Penicillin G(07/02/2026)				
18.A. Functional Limitations Ambulation					18.B. Activities Permitted Independent at Home, 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 Pneumonia due to other streptococci, 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:<div>The patient is an 88-year-old female with a significant past medical history of asthma, hypertension, hyperlipidemia, coronary artery disease, chronic diastolic heart failure, gastroesophageal reflux disease (GERD), prior cerebrovascular accident (CVA), cardiac valve replacement, pulmonary hypertension, and recent acute hypoxic respiratory failure secondary to rhinovirus infection with superimposed bacterial pneumonia complicated by septic shock and syndrome of inappropriate antidiuretic hormone secretion (SIADH). The patient was referred for skilled home health physical therapy evaluation following hospitalization and subacute rehabilitation due to a marked functional decline, generalized weakness, impaired mobility, and decreased overall functional independence. Assessment revealed bilateral lower extremity weakness, impaired balance, decreased endurance with dyspnea on exertion, and altered gait mechanics requiring the use of a walker for safe ambulation. These impairments have resulted in difficulty performing bed mobility, transfers, and safe household ambulation, significantly increasing the patient's risk for falls and further functional decline. Skilled physical therapy is medically necessary to implement a comprehensive rehabilitation program focused on lower extremity strengthening, balance training, gait retraining, transfer training, endurance conditioning, energy conservation techniques, and fall prevention strategies. Patient education was provided regarding mobility safety, proper use of the walker, activity pacing, and fall prevention measures to promote safe functional mobility. The plan of care is to continue skilled home health physical therapy to maximize functional independence, improve mobility and safety, enhance activity tolerance, reduce fall risk, and minimize the likelihood of rehospitalization while supporting the patient in returning to her highest attainable level of function.</div><div> </div><div>Date of Order</div><div>07/27/2026</div><div>Orders</div><div>Physician Face-to-Face Date: 07/07/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat OT-eval & treat due to Pneumonia due to other streptococci</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div> </div><div>>1 - SOC - PT Notes: soc</div><div> </div><div>>Physician</div><div>Tansinda, James</div></div>									
SN Careplans					SN Goals				
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 07/27/2026							25. Date HHA Received Signed POT		
24. Physician's Name and Address James Tansinda 726 Maiden Choice Catonsville, MD 21228 PHONE: 14107441101 FAX: 14107441186 NPI: 1184690141					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 : 07/07/2026				
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. PAGE 1 of 3				

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PT Careplans PT WK1: 3 (07/27/2026 - 08/01/2026), WK2: 4 (08/02/2026 - 08/08/2026), WK3: 1 (08/09/2026 - 08/15/2026), WK4: 1 (08/16/2026 - 08/21/2026) 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: 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:Living Will PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170K1 - Walk 150 Feet, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, muscle weakness, limited endurance, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep	PT Goals PATIENT-STATED GOAL: not to go back to the hospital GOALS Chair to Bed to Chair - 06. Independent Toilet Transfer - 06. Independent Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance 1 - Step (curb) - 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 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 Sit to Stand - 06. Independent Car Transfer - 06. Independent Walk 10 Feet - 05. Setup or clean-up assistance Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance Walk 150 Feet - 05. Setup or clean-up assistance 4 Steps - 05. Setup or clean-up assistance 12 Steps - 05. Setup or clean-up assistance Picking Up Object - 05. Setup or clean-up assistance 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
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/27/2026

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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, * 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, 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	
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