Home Health Certification and Plan of Care

Order ID: 1150/20996

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
10051531	07/31/2026	From: 07/31/2026 To: 09/28/2026	28421	217058

6. Patient's Name and Address

Dora Raga
1812 Glen Cove Road,
DARLINGTON, MD 21034-
443-220-5762

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 04/27/1934 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M17.0	Bilateral primary osteoarthritis of knee	07/31/26

13. ICD	Other Pertinent Diagnoses	Date
I69.320	Aphasia following cerebral infarction	07/31/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	07/31/26
N18.9	Chronic kidney disease u	07/31/26
J44.9	Chronic obstructive pulmonary disease unspecified	07/31/26
I48.0	Paroxysmal atrial fibrillation	07/31/26
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	07/31/26
E78.5	Hyperlipidemia unspecified	07/31/26
H40.9	Unspecified glaucoma	07/31/26
F41.9	Anxiety disorder unspecified	07/31/26
F32.A	Depression unspecified	07/31/26
R19.00	Intra-abd and pelvic swelling mass and lump unsp site	07/31/26
F17.210	Nicotine dependence cigarettes uncomplicated	07/31/26
Z79.82	Long term (current) use of aspirin	07/31/26

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

Sertraline Hcl - Sertraline Hydrochloride 50 MG / 1 Tablet by mouth daily
Pantoprazole Sodium - Pantoprazole Sodium Delayed Release 40 MG / 1 Tablet by mouth EVERY DAY 1/2 - 1 HOUR BEFORE MORNING MEAL
Oxybutynin Chloride - Oxybutynin Chloride 0 Extended Release 24 Hour 15 MG / 1 Tablet by mouth daily
LISINOPRIL 30 MG / 1 Tablet by mouth daily
Cardizem Cd - Diltiazem Hydrochloride Extended Release 24 Hour 360 MG / 1 Capsule by mouth daily
Atorvastatin Calcium - Atorvastatin Calcium 40 MG / 1 Tablet by mouth daily
COLACE 100 MG / 1 Capsule by mouth daily as needed
ASPIRIN 0 Delayed Release 81 MG tablet Oral once a day
Diclofenac Sodium - Diclofenac Sodium 0 External Gel 1% / 2 grams to affected area topically 4 times per day

14. DME and Supplies:

bath bench, walker

15. Safety Measures:

standard precautions, fall precautions, ambulates with device, walker precautions, bathroom safety

16. Nutrition:

low sodium,

17. Allergies:

hydrocodone

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

No Restrictions

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: Yes

20. Prognosis: fair

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 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 a 92-year-old female referred to home health services following a decline in ambulation and progressive generalized weakness. Her past medical history is significant for bilateral knee osteoarthritis, cerebrovascular accident (CVA) with residual aphasia/slurred speech, paroxysmal atrial fibrillation, gastrointestinal bleed, chronic kidney disease, chronic obstructive pulmonary disease (COPD), spondylosis, hyperlipidemia, anxiety, depression, and pelvic mass. During a recent telehealth visit with her primary care provider, accompanied by her daughter, the patient reported generalized weakness and bilateral knee pain, prompting a request for home health therapy services, including physical therapy, occupational therapy, and speech therapy. Skilled nursing completed an evaluation only per the family's request, as they primarily desired therapy services and speech therapy was unavailable through the agency. On assessment, the patient was alert and oriented 4 with slurred speech noted. Lung sounds were clear to auscultation bilaterally, bowel sounds were active in all quadrants, and skin was warm, dry, and intact. The patient denied shortness of breath, headache, nausea, and vomiting. She reported intermittent bilateral knee and lower back pain rated 3/10, as well as generalized weakness. Medication reconciliation was completed with the patient and her daughter. Education was provided regarding medication compliance, fall prevention strategies, and personal hygiene. The patient independently monitors and records her blood pressure daily, and her daughter organizes weekly medications in a pill organizer. The patient lives alone in a mobile home with four steps and bilateral handrails at the entrance. Her daughter, Carmen, lives nearby and, along with her other children, provides assistance as needed. Due to generalized weakness, the patient has remained homebound for an extended period. Physical therapy evaluation revealed significant functional impairments affecting mobility and safety. Although the patient reported no recent falls and was previously modified independent with transfers, ambulation using a rollator, stair negotiation, and activities of daily living, she currently demonstrates lower extremity weakness, greater on the left than the right, impaired dynamic balance, unsteady gait with a rollator, difficulty negotiating stairs, and a Timed Up and Go (TUG) score of 21.7 seconds, indicating an increased risk for falls. The patient also exhibited high anxiety and a pronounced fear of falling, which limited accurate assessment of the Tinetti Balance Test. Bed mobility remained independent; however, supervision with verbal cueing was required for transfer safety. A home exercise program consisting of seated lower extremity exercises, including heel raises, toe raises, long arc quadriceps, and hip flexion (3 sets of 10 repetitions), was initiated. The patient's daughter was instructed on providing manual resistance during exercises to facilitate strengthening and promote safe participation. Occupational therapy evaluation demonstrated that the patient remains independent with basic self-care activities, functional transfers, and functional ambulation despite her reported generalized weakness. Based on the evaluation findings, no additional skilled occupational therapy services were recommended, and the patient was discharged following the evaluation only. Skilled physical therapy remains medically necessary to address lower extremity weakness, impaired balance, gait deficits, decreased confidence with mobility, stair negotiation, and fall risk through therapeutic exercise, gait and balance training, transfer training, patient and caregiver education, and progression of an individualized home exercise program to maximize safety, functional mobility, and independence within the home environment.
 Date of Order 07/31/2026 Orders Physician Face-to-Face Date: 07/14/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/31/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Amber Vasold
16 Aberdeen Shopping Plaza
Aberdeen, MD 21001
PHONE: 4102728844 FAX: 14102728910 NPI: 1013389683

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 : 07/14/2026

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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& treat 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 home
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Vasold, Amber

SN Careplans

SN WK1: 1 (07/31/26-08/01/26)

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: 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, dose, interactions of all new/change meds
Advance Directive:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, muscle weakness, daytime fatigue, balance deficit, Pain Interference with ADLs

PROCEDURES: cough/deep breathing 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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

SN Goals

PATIENT-STATED GOAL: No patient stated goal as this is an SN eval only.

GOALS
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
* 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

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

07/31/2026

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PT WK1: 3 (08/01/26-08/01/26) ,WK2: 3 (08/02/26-08/08/26)

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: Medication management : Review.\nMedication with patient and caregiver, home exercise program: Seated Knee extension hip flexion, hip abduction heel raises toe raises all with manual resistance or use of therabands. Standing exercises as tolerated with upper extremity support, including heel, raises hamstring curls, hip flexion. Hip abduction as tolerated., dynamic standing balance exercises: Focus on Balance correction, improving reaction time Improving ankle hip and step strategies to reduce risk for falls, gait training on uneven surfaces, gait training/stair training, transfers training

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 - 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, Picking Up Object - 05. Setup or clean-up assistance

PATIENT-STATED GOAL: To walk better get stronger improve my balance not be so afraid of falling and to get back to going to church

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

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

Picking Up Object - 05. Setup or clean-up assistance

OT Careplans

OT WK1: 3 (08/01/26-08/01/26) ,WK2: 3 (08/02/26-08/08/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: home exercise program: Bilateral UE strengthening of triceps extensions, biceps curls, armchair press-ups, triceps extensions

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: Evaluation only

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	07/31/2026