Home Health Certification and Plan of Care

Order ID: 1150/21327

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6TN1V95FN38	08/13/2026	From: 08/13/2026 To: 10/11/2026	28920	217058

6. Patient's Name and Address
Christa Gahagan
333 Hopkins Landing Drive,
ESSEX, MD 21221-
410-236-9971

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 07/05/1958 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I10.	Essential (primary) hypertension	08/13/26

13. ICD	Other Pertinent Diagnoses	Date
E03.9	Hypothyroidism unspecified	08/13/26
M06.9	Rheumatoid arthritis unspecified	08/13/26
Z79.01	Long term (current) use of anticoagulants	08/13/26
Z79.890	Hormone replacement therapy	08/13/26
Z79.891	Long term (current) use of opiate analgesic	08/13/26
Z91.81	History of falling	08/13/26

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

HYDROCHLOROTHIAZIDE 25 mg mg (1 tablet(s)) by mouth Daily Indication: htn
COZAAR 100 mg 100MG; 1 TAB by mouth Daily Indication: htn
TYLENOL 650MG; 1 TAB by mouth Every Six Hours PRN for mild pain 1-3. Not to exceed 4gm Acetaminophen/24hrs
HYDROXYCHLOROQUINE SULFATE 200 mg mg (1 tablet(s)) by mouth Daily Indication: ra
ROSUVASTATIN CALCIUM 5 mg 5MG; 1 TAB by mouth Daily Indication: hld
ROBAXIN 500 mg mg (1 1/2 tablet(s)) by mouth Every Eight Hours PRN Indication: muscle spasm
LEVOTHYROXINE 125 mcg (1 tablet(s)) by mouth daily at 6am Indication: hypothyroid
Acetaminophen And Codeine Phosphate - Acetaminophen: Codeine Phosphate 300 mg;30 mg 1 CAP by mouth every 6 hours AS NEEDED FOR PAIN
PULMICORT mg (2 mL) via nebulizer twice a day RT TI Symbicort Pair with Brovana BID Indication: bronchospasm prevention
BROVANA 15 mcg (2 mL) via nebulizer twice a day RT TI Symbicort Pair with Brovana BID Indication: bronchospasm prevention

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

15. Safety Measures:
standard precautions, fall precautions, ambulates with device, walker precautions, medication safety, supervision at all times

16. Nutrition:
low sodium, low cholesterol

17. Allergies:
no known allergies

18.A. Functional Limitations
None of the above

18.B. Activities Permitted
Cane, Exercises Prescribed, Walker

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
patient 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 was referred to home health services following a recent fall after being struck by a wave, resulting in an acute L1 vertebral compression fracture with mild loss of height of the superior endplate. The injury was managed conservatively without surgical intervention, and the patient subsequently completed approximately 10 days of inpatient rehabilitation for ambulatory dysfunction. Past medical history is significant for rheumatoid arthritis, vertigo, hypertension, hypothyroidism, and history of sigmoid colectomy. The patient previously lived alone in a condominium with elevator access and was independent with basic activities of daily living, instrumental activities of daily living, community mobility, driving, transfers, and functional ambulation. She now requires assistance from her sister with ADLs and IADLs as needed and is subject to spinal precautions related to the acute compression fracture. Upon assessment, the patient was alert and oriented x3 and reported lower back pain, particularly with movement and while in bed. Current pain management includes Tylenol with codeine, a lidocaine patch, and a muscle relaxant. The patient denied shortness of breath and reported a bowel movement today. Trace bilateral lower-extremity edema was noted. She demonstrates a slow gait and requires a rolling walker for safe ambulation. Physical therapy assessment identified impaired balance, proximal lower-extremity weakness, difficulty walking, and mild difficulty with transfers. Tinetti score was 17/28, indicating impaired balance and increased fall risk, while Timed Up and Go (TUG) was 15 seconds, consistent with decreased functional mobility. The patient was instructed in safe transfer techniques, including transferring into and out of her stand-up shower, and was able to demonstrate the technique with fair success. She remains motivated to participate in therapy and demonstrates good rehabilitation potential for progression toward her prior level of function. Skilled nursing services are ordered at a frequency of 1 visit weekly for 3 weeks, with physical and occupational therapy evaluation and treatment. Skilled nursing interventions include assessment and monitoring of pain, mobility, edema, safety, and overall clinical status; medication reconciliation; and education regarding medication names, doses, frequency, indications, and pertinent potential side effects. The patient was instructed on effective pain-management strategies and measures to assist with lower-extremity edema, including appropriate positioning and activity as tolerated. Education was also provided regarding fall prevention, safe use of the rolling walker, adherence to spinal precautions, and safe performance of functional activities. The patient was receptive to all education provided. Skilled physical therapy is medically necessary to address impaired gait, decreased balance, proximal lower-extremity weakness, transfer difficulty, reduced functional mobility, and increased fall risk following the L1 compression fracture. PT will focus on safe mobility, strengthening, balance training, transfer training, gait training with the rolling walker, fall prevention, and progression of functional independence while maintaining prescribed spinal precautions. Skilled occupational therapy is also indicated due to decreased standing balance and tolerance, reduced bilateral upper-extremity strength, decreased activity tolerance, and resulting limitations in self-care, functional transfers, and functional ambulation. OT will address ADL retraining, safe transfers, functional mobility, activity tolerance, upper-extremity strengthening, compensatory strategies, and home safety to facilitate a safe return to the patient's previous level of independence. Continued skilled interdisciplinary home health services are recommended to promote recovery, reduce pain and fall risk, improve functional mobility and safety, and maximize independence while the patient continues to recover from the acute L1 compression fracture.
 Date of Order 08/13/2026 Orders Physician Face-to-Face Date: 08/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, 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 - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Massari, Luisa

SN Careplans | SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 08/13/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Luisa Massari
3346 Paper Mill Rd
Phoenix, MD 21131
PHONE: 4104272020 FAX: 14104272013 NPI: 1225075567

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 : 08/06/2026

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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SN WK1: 1 (08/13/26-08/15/26) ,WK2: 1 (08/16/26-08/22/26) ,WK3: 1 (08/23/26-08/29/26)

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:UNKNOWN

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, swelling in the arms/legs, M1033 - Exhaustion, M1400 - Dyspnea, limited range of motion, limited strength, muscle spasms, limited endurance, balance deficit, Pain Effect on Sleep, Pain Interference with Therapy activities, 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, * 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, meal preparation is available to patient for all meals

PATIENT-STATED GOAL: TO BE PAIN FREE

GOALS
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
* 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
* 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

meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (08/13/26-08/15/26) ,WK2: 1 (08/16/26-08/22/26) ,WK3: 1 (08/23/26-08/29/26) ,WK4: 1 (08/30/26-09/05/26) ,WK5: 1 (09/06/26-09/12/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, 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 medication with pt and caregiver, cough/deep breathing exercises, incentive spirometer, home exercise program: Standing hip flexion, heelraises, hamstring curls, hip abduction with ue support use cuff weights as needed. Seated laq, gait training on uneven surfaces, gait training/stair training, transfers training

PT Goals

PATIENT-STATED GOAL: To get off the walker and be able to participate in sports

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Signature of Physician:

Date

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

Date
08/13/2026

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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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 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

* 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

Sit to Stand - 06. Independent

Car Transfer - 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

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

OT Careplans

OT WK2: 1 (08/16/26-08/22/26) ,WK4: 1 (08/30/26-09/05/26) ,WK6: 1 (09/13/26-09/19/26) ,WK8: 1 (09/27/26-10/03/26)

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: Medication Review : Medication reviewed with patient with all medications in the home, home exercise program: Bilateral UE triceps extensions, biceps curls, shoulder raises 2-3 sets 8-12 reps, 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 - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Babysitting;Babysitting;Babysitting

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

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

Signature of Physician:

Date

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

Date
08/13/2026