Home Health Certification and Plan of Care

Order ID: 1150/21501

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
11351574420	08/20/2026	From: 08/20/2026 To: 10/18/2026	26514	217058

6. Patient's Name and Address
Ethel Osuagwu
7837 Man,
SEVERN, MD 21144-
443-597-9273

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 11/26/1954 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M53.3	Sacrococcygeal disorders not elsewhere classified	08/20/26

13. ICD	Other Pertinent Diagnoses	Date
E89.0	Postprocedural hypothyroidism	08/20/26
E11.9	Type 2 diabetes mellitus without complications	08/20/26
I10.	Essential (primary) hypertension	08/20/26
G25.0	Essential tremor	08/20/26
E78.5	Hyperlipidemia unspecified	08/20/26
K21.9	Gastro-esophageal reflux disease without esophagitis	08/20/26
Z90.09	Acquired absence of other part of head and neck	08/20/26
Z79.4	Long term (current) use of insulin	08/20/26
Z79.899	Other long term (current) drug therapy	08/20/26
Z98.1	Arthrodesis status	08/20/26

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

Lidocaine Patch - Lidocaine 5 % / 1 patch topical once a day remove after 12 hours
LISINOPRIL 40 MG / 1 Tablet Orally once a day
Metformin Hcl - Metformin Hydrochloride 1000 MG / 1 Tablet Orally twice a day with a meal
Atorvastatin Calcium - Atorvastatin Calcium 20 MG / 1 Tablet Orally once a day
Sitagliptin Phosphate - Sitagliptin Phosphate 100 MG / 1 Tablet by mouth once daily
Lantus Solostar - Insulin Glargine Recombinant Solution Pen-Injector 100 UNIT/ML / 34 units subcutaneous one daily
LANTUS 3 Bottles Solution subcutaneous once a day

14. DME and Supplies:
rolling walker, diabetic supplies, bath bench, grab bars, cane

15. Safety Measures:
transfer with assist, fall precautions, diabetic precautions, avoid temperature extremes, ambulates with device, emergency phone number prominently displayed, standard precautions, ambulates with assistance, walker precautions, smoke detectors , medication safety, bathroom safety, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
meloxicam

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Cane, Walker, Transfer bed/Chair, Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, 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
PT: family/caregiver will be responsible for managing treatment
OT: patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Sacrococcygeal disorders not elsewhere classified, 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:

PT/OT Start of Care/admission evaluation was completed for a 71-year-old female referred by her physician for home health therapy due to generalized weakness, difficulty with transfers, decreased functional mobility, impaired balance, and decreased safety with mobility, as reported by her daughter, Ugochi. The patient was seen by her physician the previous week, and a referral was made for skilled home PT services. The patient has a history of hospitalization in March/April following T1-T5 spinal fusion surgery and also has a surgical history significant for thyroidectomy. She currently reports neck pain and difficulty swallowing. The patient resides in a home with one step to enter and approximately 15 steps to access the second-floor bedroom and bathroom. She has caregivers available with her at all times. Prior to admission, she primarily ambulated within the home using a single-point cane, which she has used for several years. She reports one fall within the past two months and two falls within the past year, indicating an ongoing elevated fall risk. Medication reconciliation, home safety assessment, and functional assessment were completed. The patient presents with decreased bilateral lower-extremity and upper-extremity strength, decreased activity and standing tolerance, impaired functional mobility, difficulty with transfers and stair negotiation, unsteady gait, decreased balance, decreased safety awareness, history of falls, and increased risk for further falls and functional decline. Skilled PT intervention included instruction in safe transfers using a walker, with cues provided for appropriate hand and foot placement, forward weight shifting, and reaching back for the chair prior to sitting. The patient required minimal assistance to standby assistance for safe transfers. Bed mobility training was also provided, with instruction in proper body mechanics and techniques to promote greater independence; the patient required minimal assistance to safely complete bed mobility. The patient was instructed in safe ambulation on level surfaces using a walker and required standby assistance, with cues for maintaining appropriate positioning within the walker, increasing bilateral step height and step length, and improving overall safety. Tinetti and Timed Up and Go (TUG) assessments were performed. Due to current gait instability and fall risk, the patient was instructed to use the walker at all times for safety. Therapeutic exercise instruction was initiated, including supine ankle pumps, quadriceps sets, and gluteal sets, 1 set of 20 repetitions each, as well as heel slides, 1 set of 10 repetitions. A written copy of the home exercise program (HEP) was left in the home, and the patient was instructed to perform the exercises twice daily as tolerated. The patient was also educated regarding the importance and benefits of regular daily ambulation to promote circulation, maintain strength and endurance, and reduce complications associated with prolonged inactivity. She was instructed to begin with short walks in the home every 1-2 hours, as tolerated, initially completing approximately 1-2 short walks and gradually progressing from 3-5 minutes as endurance improves. Education was provided regarding edema management, including the causes of edema and positional strategies such as elevating the lower extremities above heart level during rest periods and using compression garments only if recommended by the physician. The patient verbalized understanding of the education provided. She was also instructed regarding signs and symptoms of infection involving any surgical incision or wound, including fever, chills, redness, swelling, increased pain, bleeding, or drainage, as well as persistent nausea, vomiting, or pain not relieved by prescribed medication. The patient was educated using pages 32-33 of the patient handbook regarding home safety, fall prevention, fall risk factors, and environmental modifications to reduce the risk of injury. Pain was reported to be well controlled with the current medication regimen. The patient was instructed regarding effective pain-management strategies, including taking prescribed pain medication at the onset of pain and monitoring for potential adverse effects such as dizziness and constipation. She was instructed to notify her healthcare provider for concerning or uncontrolled symptoms and to call 911/EMS for chest pain, shortness of breath, or severe/unrelieved pain. The patient was also advised, as appropriate, to take pain medication approximately one hour before scheduled PT visits to facilitate participation and tolerance of therapeutic activities. Ice application was instructed for the affected area for approximately 20 minutes using an appropriate protective barrier, with skin assessment every five minutes; the specific treatment area was not documented. Skilled OT intervention is indicated to address the patient's decreased activity tolerance, reduced standing tolerance,

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 08/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Nnaemeka Agajelu
85 Kendrick Way
Glen Burnie, MD 21061
PHONE: 410-553-6360 FAX: 14105536661 NPI: 1104891886

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 : 07/31/2026

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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impaired upper-extremity strength, difficulty with instrumental and basic activities of daily living, impaired functional mobility, transfer difficulties, decreased safety awareness, and need for assistance with daily tasks. OT will focus on improving functional strength, activity and standing tolerance, safe transfer techniques, ADL/IADL performance, energy conservation, safety awareness, and compensatory strategies to promote greater independence and safety within the home. The patient and primary caregiver participated in discussion and development of the therapy plan of care and were in agreement with the established goals and interventions. PT services are planned to begin 08/20/2026 at a frequency of 1 visit during the first week, 2 visits per week for one week (Tuesday/Thursday), followed by 1 visit per week for four weeks (Tuesday). The referring physician, Dr. Agajelu, was notified that the admission was completed. During one attempted admission visit, the patient's daughter was unavailable to provide consent because she had gone to the basement to work and could not be disturbed; therefore, required consents were to be obtained at the next visit. The patient is considered homebound due to weakness, unsteady gait, impaired balance, history of falls, decreased functional mobility, and need for an assistive device and human assistance. She requires the use of a walker and assistance from another person to safely leave the home, and leaving the home requires a considerable and taxing effort, making routine trips outside the home difficult and potentially unsafe. Without continued skilled home health therapy, the patient remains at increased risk for falls, further functional decline, decreased independence, and loss of safe mobility within the home. Skilled PT and OT services are medically necessary to address these deficits, maximize functional independence, improve safety with transfers and ambulation, facilitate safe stair negotiation and ADL performance, and reduce the risk of falls and further decline.
 Date of Order 08/20/2026 Orders Physician Face-to-Face Date: 07/31/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat, OT-eval & treat due to Sacrococcygeal disorders not elsewhere classified 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 Agajelu, Nnaemeka

SN Careplans

SN Goals

PT Careplans

PT WK1: 1 (08/20/26-08/22/26) ,WK2: 2 (08/23/26-08/29/26) ,WK3: 1 (08/30/26-09/05/26) ,WK4: 1 (09/06/26-09/12/26) ,WK5: 1 (09/13/26-09/19/26) ,WK6: 1 (09/20/26-09/26/26)

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: 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, 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

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.

PT Goals

PATIENT-STATED GOAL: To be able to get around better

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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's living environment is clean/uncluttered

caregiver performs medical/rehabilitation treatments with adequate competence

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 - 05. Setup or clean-up assistance

Shower/Bathe Self - 04. Supervision or touching assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

08/20/2026

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; 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:No Advance Directive

08/20/2026 Problems : GG0170I1 - Walk 10 Feet
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
GG0170K1 - Walk 150 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170G1 - Car Transfer
GG0170F1 - Toilet Transfer
GG0170D1 - Sit to Stand
M1400 - Dyspnea
M2020 - Oral Med Management
Home Safety
muscle weakness
M2102d - Caregiver Performs Treatment

PROCEDURES: train caregiver(s) to perform medical/rehabilitation treatments: Administration of HEP, home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., therapeutic modalities: Apply ice to bilateral knees x 20 minutes with necessary barrier and skin assessments q 5 minutes., equipment training: Walker/cane, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training, coordinate/arrange for maintenance of clean/uncluttered living area

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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered, 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 - 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 - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

OT Careplans

OT WK1: 1 (08/20/26-08/22/26) ,WK2: 1 (08/23/26-08/29/26) ,WK3: 1 (08/30/26-09/05/26) ,WK4: 1 (09/06/26-09/12/26) ,WK5: 1 (09/13/26-09/19/26) ,WK6: 1 (09/20/26-09/26/26)

08/21/2026 Problems : 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: cough/deep breathing exercises, incentive spirometer, home exercise program: Deep breaths and exe for shoulder elbow and wrist, 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 - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff

OT Goals

PATIENT-STATED GOAL: To be able to walk and do all her BADLs and IADLs

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

Shower/Bathe Self - 06. Independent

Don/Doff Footwear - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Eating - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

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Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent	Upper Body Dressing - 06. Independent

Signature of Physician:	Date
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