HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022008

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
6HG3PN5AM73	07/13/2026	09/11/2026 - 11/09/2026	27855	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Pansy Cerato 971 Seneca Park Road Middle River, MD 21220	Female	12/13/1940	410-335-4171
	Email		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI: 1487113239		Fax Number: 410-559-3002

Clinical Condition Requiring Homecare:

PT recertification was completed this date. The patient is an 85-year-old female receiving skilled PT/OT services following hospitalization and subacute rehabilitation secondary to CVA. Her PMH is significant for a remote subarachnoid hemorrhage, breast cancer status post lumpectomy, chemotherapy, and radiation, and GERD. Prior to her current decline, the patient lived with her husband in a single-family home and was independent with basic self-care, functional transfers, and ambulation using a rollator. Throughout treatment, her husband has remained actively involved in her care and family education, including bed mobility, sit-to-stand and stand-pivot transfers with proper hand and foot placement, gait training with a rolling walker, wheelchair mobility and negotiation using bilateral upper extremities and the left lower extremity, toilet and car transfers, and safe wheelchair negotiation over a single step and ramp. Education has also been provided regarding adherence to the lower-extremity home exercise program at least three times weekly and the need for a stable, code-compliant ramp for safe home entry; however, the current ramp consists of 2 x 8-inch lumber covered with plywood. The patient has demonstrated measurable progress in functional mobility, and her husband's safety awareness and techniques for assisting her have improved. Despite progress, she continues to present with decreased standing balance, standing tolerance, bilateral upper-extremity strength, and activity tolerance, resulting in impaired independence with self-care, functional transfers, and ambulation. Continued skilled PT/OT intervention is recommended to address these deficits, reinforce patient and caregiver training, improve safety and functional mobility, and maximize the patient's potential to progress toward her prior level of independence.<o:p></o:p>

Date of Order
09/08/2026
Order<o:p></o:p>
Physician Face-to-Face Date:
07/02/2026<o:p></o:p>
Clinical Condition Requiring Home Care per

Physician Statement on 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

Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Essential (primary) hypertension<o:p></o:p> Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p> 4 - Recertification PT Notes: to address these deficits, reinforce patient and caregiver training, improve safety and functional mobility, and maximize the patient's potential to progress toward her prior level of independence.<o:p></o:p> OT Eval Notes:<o:p></o:p> Physician: Brodine, Joseph	

ICD-10 CM Principal Diagnosis: I10.. Essential (primary) hypertension

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
I50.21	Acute systolic (congestive) heart failure	NEBIVOLOL HYDROCHLORIDE 5 mg/tablet / Give 0.5 tablet by mouth one time a day for HTN Hold for SBP<110 or HR<50 LOSARTAN POTASSIUM 25 MG / 1 Tablet by mouth once a day for HFrEF ACETAMINOPHEN 325 mg/tablet / Give 2 tablet by mouth every 6 hours as needed for Pain Notify Physician/Advanced Practice Provider if pain persists. Do not exceed 3g/day Acetaminophen - Acetaminophen 500 mg/tablet / Give 2 tablet by mouth at bedtime for knee pain
I42.9	Cardiomyopathy unspecified	
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	
I44.7	Left bundle-branch block unspecified	
K21.9	Gastro-esophageal reflux disease without esophagitis	
H74.02	Tympanosclerosis left ear	
E66.9	Obesity unspecified	
Z68.32	Body mass index [BMI] 32.0-32.9 adult	
Z86.79	Personal history of other diseases of the circulatory system	
Z85.3	Personal history of malignant neoplasm of breast	
Z86.711	Personal history of pulmonary embolism	

Prognosis good	**Mental and Psychosocial Status** COGNITION: 2. Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance)., ANXIETY: , SOCIAL ISOLATION: , BEHAVIORAL ISSUES: Wfl , HISTORY OF DEPRESSION:
Functional Limitations Speech, Ambulation, Endurance, Hearing, Bowel/Bladder Incontinence	**Activities Permitted** Exercises Prescribed, Up As Tolerated, Transfer bed/Chair, Wheelchair, Walker
DME & Supplies rolling walker, wheelchair, commode, cane, 4 wheeled walker	**Safety Measures** transfer with assist, supervision at all times, standard precautions, hip precautions, fall precautions, ambulates with device, ambulates with assistance, activity supervision
Nutrition Z. NO PHYSICIAN-ORDERED DIET	**Allergies** Zetia, Statins, Sulfa Antibiotics, CONTRAST MEDIA

Advance Directives
Durable power of attorney for health care/Medical power of attorney

Caregiver Status

Rehabilitation Potential
SELF-CARE: , MOBILITY:

DISCHARGE PLAN:
PT: family/caregiver will be responsible for managing treatment

OT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

PT Eval

4 - Recertification PT

OT Eval

SN NARRATIVE
The patient is AXOX4; she is an 85-year-old female with a PMHx of remote subarachnoid, history of breast cancer, s/p lumpectomy, chemo, and radiation, and GERD, etc. She presented to the ER with an acute onset of headache, nausea, and vertigo. She was intubated due to being hypoxic and was placed on a non-rebreather mask. She is now on room air with an oxygen saturation of 98%. She was diagnosed with a right cerebellar hemorrhage. She has right-sided weakness and is unable to walk. She sits in a wheelchair but has yet to learn how to wheel herself. She lives with her husband and requires help with her ADL's. Her skin is warm and intact. Her vitals were WNL. Her husband is her primary caregiver. Medication review review was completed. Teaching was provided on the need to check and document her blood pressure, medication compliance, etc.

OT CAREPLAN
OT frequency WK2: 1 (09/13/26-09/19/26),WK4: 1 (09/27/26-10/03/26),WK6: 1 (10/11/26-10/17/26),WK8: 1 (10/25/26-10/31/26)

09/15/2026 Problems : 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, cough/deep breathing exercises, incentive spirometer, home exercise program: Bilateral UE triceps extensions, biceps curls, armchair press-ups 2-3 sets 8-12 reps, equipment training, work simplification/energy conservation, transfers training: Skilled OT, assist with bathing: Skilled OT, assist with grooming: Skilled OT, assist with lower body dressing: Skilled OT, assist with upper body dressing: Skilled OT

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 - 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 NARRATIVE
The patient is an 85-year-old female presenting to skilled OT services s/p hospitalization with sub acute rehabilitation secondary to cva. PMH significant for remote subarachnoid, history of breast cancer, s/p lumpectomy, chemo, and radiation, and GERD. Patient previously resided with her husband in a SFH. Patient completed basic self care, functional transfer and functional ambulation tasks independently utilizing Rollator.

Patient currently presents with decreased standing balance, standing tolerance, bilateral UE strength and activity tolerance resulting in decreased self care, functional transfer and functional ambulation independence. Skilled OT services recommended at this time to address deficits hindering Patient from returning to prior level of functional independence.

OT GOALS
PATIENT-STATED GOAL: Get in the shower

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

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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

PT CAREPLAN

PT frequency WK2: 1 (09/13/26-09/19/26),WK3: 1 (09/20/26-09/26/26),WK4: 1 (09/27/26-10/03/26),WK5: 1 (10/04/26-10/10/26),WK6: 1 (10/11/26-10/17/26),WK7: 1 (10/18/26-10/24/26),WK8: 1 (10/25/26-10/31/26)

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: Wfl

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

09/15/2026 Problems : GG0170D1 - Sit to Stand
GG0170J1 - Walk 50 ft with 2 Turns
GG0170K1 - Walk 150 Feet
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170I1 - Walk 10 Feet
GG0170P1 - Picking Up Object
GG0170E1 - Chair to Bed to Chair
GG0170G1 - Car Transfer
GG0170N1 - 4 Steps
GG0170O1 - 12 Steps
GG0170M1 - 1 - Step (curb)
GG0170S1 - Wheel 150 feet
GG0170R1 - Wheel 50 ft w 2 Turns
GG0170F1 - Toilet Transfer
dizziness/syncope
dependent edema
impaired speech
extremity burn/tingle/numb
weak hand grips
balance deficit
frequent urination
muscle weakness
swelling of affected area

PT NARRATIVE

PT recertification completed this day. Throughout her treatment husband is very Involved. We have been working extensively on pt amd family ed on bed mobility, sit to stand and stand pivot transfers proper hand and foot placement, gait training with rw, wheelchair negotiation using her bilateral ues and lle., toilet transfers, husband negotiating pt in wheelchair up and down single step negotiating pt up and down ramp in wheelchair, car transfers. I have encouraged on multiple occasions to get a stable and up to code ramp to enter home which he has yet to do. He is using 2x8" lumber covered with plywood. Also to get pt to follow le hep at least 3xweek. She has made measurable progress in all areas and husband's safety and techniques assisting pt are improving well. All areas need further training. Pt has good potential to benefit from further skilled therapeutic Intervention to address all the functional mobility areas listed above.

PT GOALS

PATIENT-STATED GOAL: To further improve my strength, stand and walk easier. Get back to going to church

GOALS
patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

Wheel 50 ft w 2 Turns - 06. Independent

Car Transfer - 05. Setup or clean-up assistance

Gait training

Ramp and curb negotiation via wheelchair

limited endurance
limited strength
obesity
M1033 - Exhaustion

PROCEDURES: Gait training: Focus on ambulation over level surfaces with rollator or rw with assistance focus maintaining wider bos, short distances, Medication management : Review medication with pt and caregiver, Curb negot in wheelchair : Continue trainhusband negotiating pt in wheelchair up and down a single step, cough/deep breathing exercises, wheelchair training: Negotiate wc using her bilateral ues and lle over level surfaces in the home,, home exercise program: Knee extension, hip flexion, hip abduction, hamstring curls, heelraises, toe raises 2x10, transfers training

TEACH PATIENT/CAREGIVER: * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Wheel 50 ft w 2 Turns - 06. Independent, Car Transfer - 05. Setup or clean-up assistance, Gait training, Ramp and curb negotiation via wheelchair

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/08/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.
F2F date: 07/02/2026

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.

Certifying Physician or Allowed Practitioner Name and Address **Joseph Brodine**
9101 Franklin Square Dr
Baltimore, MD 21237
NPI 1467987446

Phone Number 4437772000

Fax Number 18668579388

Physician's Signature and Date Signed

X

Joseph Brodine, MD
07/02/2026: Date of physician last face-to-face