HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022023

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
87206026	09/10/2026	09/10/2026 - 11/08/2026	20214	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Patrick Gallagher 12200 Belair Rd Apt 2 KINGSVILLE, MD 21087	Male	07/08/1964	443-421-2104
	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:

The patient is a 61-year-old male referred to home health services following a recent hospitalization and multiple falls, including a recent fall resulting in multiple facial bone fractures. Past medical history is significant for alcohol and cocaine abuse, liver cirrhosis, bacterial peritonitis, COPD, hyponatremia, seizures, tobacco use, left greater trochanter fracture, and recurrent falls. The patient currently resides alone in a cluttered room at Kings Court Motel, with clear pathways available for mobility. Prior to his recent decline, the patient was independent with ADLs, functional transfers, and ambulation using a single-point cane and was able to drive independently. Currently, the patient demonstrates significant bilateral lower-extremity weakness, bilateral upper- and lower-extremity numbness and tingling that he reports as longstanding, impaired coordination, decreased bilateral upper-extremity strength, reduced activity tolerance, impaired standing balance and tolerance, and difficulty performing functional transfers. Ambulation is extremely unsteady, placing the patient at high risk for falls, as evidenced by a Tinetti score of 2/28. These deficits significantly impair his ability to safely perform self-care activities, transfers, and functional mobility at his previous level of independence. The patient was instructed to use a rollator consistently during ambulation for improved stability and fall prevention. Skilled physical and occupational therapy are recommended to address deficits in strength, balance, coordination, activity tolerance, transfers, ambulation, and ADL performance, with the goal of improving safety, functional independence, and reducing fall risk. The patient demonstrates fair potential to benefit from continued skilled therapy services.

Date of Order
09/10/2026
Orders
Physician Face-to-Face Date: 09/04/2026
Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat, OT-eval & treat, msw due to Fracture of medial orbital wall right side 7thd

Physician Statement on Homebound Status:

Due to diagnosis of Fracture of medial orbital wall right side 7thd, 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.

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 Emmanuel-Allen, Laura	

ICD-10 CM Principal Diagnosis: S02.831D. Fracture of medial orbital wall right side 7thD

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
S02.32XD	Fracture of orbital floor left side 7thD	Lasix - Furosemide 40 mg oral tablet by mouth once a day Mirtazapine - Mirtazapine 30 mg tablet by mouth at bedtime Nicoderm Cq - Nicotine 14 MG/24HR patch,1 patch topical in the morning l, 1 time daily every morning Sodium Chloride - Sodium Chloride 1 g oral by mouth three times a day Spiriva Respimat - Tiotropium Bromide 2.5 MCG/ACT AERS inhaler ,2 puffs inhalant once a day Aldactone - Spironolactone 50 mg oral tablet by mouth once a day Flomax - Tamsulosin Hydrochloride 0.8 mg, Oral tablet by mouth once a day every evening Albuterol - Albuterol 108 (90 BASE) mcg/act,2 puffs inhalant as necessary Senokot - Senna 17.2 mg, Oral Tablet by mouth as necessary Cotazym - Pancrelipase (Amylase:Lipase:Protease) Lipase 6000, protease 19000 by mouth once a day Bactrim - Sulfamethoxazole: Trimethoprim 160mg by mouth once a day Sumatriptan - Sumatriptan 25mg by mouth as necessary Thiamine - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 100mg by mouth once a day Vitamin b 1 100mg by mouth once a day Metolazone 2.5mg by mouth once a day Methocarbamol - Methocarbamol 750 mg 1 by mouth twice a day Methocarbamol - Methocarbamol 750 mg 1 by mouth twice a day
S02.19XD	Oth fracture of base of skull subs for fx w routn heal	
S02.40FD	Zygomatic fracture left side 7thD	
S02.0XXD	Fracture of vault of skull subs for fx w routn heal	
S01.81XD	Laceration w/o foreign body of oth part of head subs encntr	
S22.41XD	Multiple fx of ribs right side subs for fx w routn heal	
S72.102D	Unsp trochan fx left femur subs for clos fx w routn heal	
M75.101	Unsp rotatr-cuff tear/ruptr of right shoulder not trauma	
M54.16	Radiculopathy lumbar region	
G89.4	Chronic pain syndrome	
I95.9	Hypotension unspecified	
J44.9	Chronic obstructive pulmonary disease unspecified	
K74.60	Unspecified cirrhosis of liver	
I87.303	Chronic venous hypertension w/o comp of bilateral low extrm	
D50.9	Iron deficiency anemia unspecified	
Z91.81	History of falling	

Prognosis fair	**Mental and Psychosocial 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: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No
Functional Limitations Ambulation, Endurance, Bowel/Bladder Incontinence	**Activities Permitted** No Restrictions
DME & Supplies hand held shower, grab bars, rolling walker, cane, bath bench, 4 wheeled walker	**Safety Measures** supervision at all times, transfer with assist, standard precautions, seizure precautions, fall precautions, ambulates with device, activity supervision, ambulates with assistance
Nutrition fluid restriction	**Allergies** no known allergies

Advance Directives
Full code

Caregiver Status
2. Non-agency caregiver(s) need training/supportive services to provide assistance

Rehabilitation Potential
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

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 - PT

OT Eval

MSW Eval

OT CAREPLAN

OT frequency WK1: 1 (09/10/26-09/12/26),WK3: 1 (09/20/26-09/26/26),WK5: 1 (10/04/26-10/10/26),WK7: 1 (10/18/26-10/24/26),WK9: 1 (11/01/26-11/07/26)

09/11/2026 Problems : Pain Effect on Sleep
Pain Interference with Therapy activities
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: Medication Review : Medication reviewed with all medications in the home, home exercise program: Bilateral biceps curls, shoulder PROM in all tolerable planes. 2-3 sets 8-12 reps, equipment training, work simplification/energy conservation, transfers training: 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 - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 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, Upper Body Dressing - 06. Independent

OT NARRATIVE

61 yo male presenting to skilled OT services s/p recent hospital admission secondary to multiple facial fractures s/p dall. Past medical history significant for etoh abuse, coccinellids abuse, liver cirrhosis, bacterial peritonitis, COPD, hyponatremia, seizures, smoker, multiplefalls, .

Patient previously resided in long-term hotel alone. Patient previously completed basic self care, functional transfer and functional ambulation tasks independently.

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: Walk better

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 - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

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

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

Eating - 06. Independent

Upper Body Dressing - 06. Independent

PT CAREPLAN

PT frequency WK1: 1 (09/10/26-09/12/26),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 > 7

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 3. Multiple hospitalizations (2

or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 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:Full code

09/10/2026 Problems : 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
GG0170I1 - Walk 10 Feet
GG0170G1 - Car Transfer
GG0170F1 - Toilet Transfer
GG0170D1 - Sit to Stand
M1720 - Anxiety
D0700 - Social Isolation
M1610 - Urinary Incontinence
M1033 - Unintentional Weight Loss

PT NARRATIVE

61 yo male referred to home health services following recent falls Most Recently suffered multiple facial bone fractures with his last fall. Past medical history significant for L greater trochanter fx, etoh abuse, coccinellids abuse, liver cirrhosis, bacterial peritonitis, COPD, hyponatremia, seizures, smoker, multiplefalls, . Pt lives at kings Court motel. Prior level of function pt amb with spc, I all transfers, I adls, drove. Pt lives in cluttered hotel room but does have clear pathways. Patient presents with lower extremity weakness. Numbness and tingling in hands and lower extremities, which is long-standing impaired coordination when walking extremely unsteady, high fall risk as evidenced by tinetti score of 2/28, Difficulty with transfers standing tolerance. Patient has fair potential to benefit from skilled physical therapy to address balance overall functional mobility and strength. Recommended to patient to use rollator at all times for walking.

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61 yo male referred to home health services following recent hospital admission. Past medical history significant for etoh abuse, coccinellids abuse, liver cirrhosis, bacterial peritonitis, COPD, hyponatremia, seizures, smoker, multiplefalls, . Pt lives at kings Court motel. Prior level of function pt amb with spc, I all transfers, I adls, drove. Pt lives in cluttered hotel room but does have clear pathways. Patient presents with lower extremity weakness. Numbness and tingling in hands and lower extremities, which is long-standing impaired coordination when walking extremely unsteady, high fall risk as evidenced by tinetti score of 2/28, Difficulty with transfers standing tolerance. Patient has fair potential to benefit from skilled physical therapy to address balance overall functional mobility and strength. Recommended to patient to use rollator at all times for walking.

Patient presents via phone assessment with significant psychosocial and resource needs following a recent fall with severe facial injuries and history of rotator cuff injuries. Patient uses a walker and requires wheelchair assistance. Patient resides in a Baltimore County hotel with spouse, who is the primary caregiver and transportation support. Household currently reports no income and limited additional support. MSW to assist with benefits and community resource navigation, including Social Security/disability application, food assistance, Meals on Wheels, and resources for obtaining reading glasses. MSW will further assess financial needs, caregiver/support needs, and eligibility for additional community-based services and coordinate with the home health team as indicated.

PT GOALS

PATIENT-STATED GOAL: I would just like to improve my function.Be able to walk easier and not fall.So much

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
* 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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase caloric intake
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
Home Safety
dependent edema
seizures
weak hand grips
balance deficit
muscle weakness
limited endurance
limited range of motion
limited strength
loss of appetite
tooth pain/decay/sensitivity
hair loss
M2102d - Caregiver Performs Treatment
M2102c - Med Admin

PROCEDURES: Medication management : Review.\nMedication with patient and caregiver, cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, train caregiver(s) to perform medical/rehabilitation treatments, apply compression bandage, monitor intake & output, bladder training, home exercise program: Laq, hip flexion, heelraises, DF, hip abduction, hamstring curls with resistance as tolerated, 2-310, Progress to standing exercises if tolerated, equipment training, work simplification/energy conservation, dynamic standing balance exercises: Work on weight, shifting, step, ankle and hip strategies improvement of reaction time to reduce risk for falls., gait training on uneven surfaces, gait training/stair training, transfers training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for maintenance of clean/uncluttered living area, coordinate/arrange long-term socialization activities

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * strategies to increase caloric intake, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin 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, * strategies to increase socialization, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered, caregiver administers and/or packages medications appropriately, 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 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, Oral Hygiene - 05. Setup or clean-up assistance, 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

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

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient's living environment is clean/uncluttered

caregiver administers and/or packages medications appropriately

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

Oral Hygiene - 05. Setup or clean-up assistance

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

MSW NARRATIVE
Patient is homebound secondary to recent fall resulting in severe facial injuries, history of rotator cuff injuries, and impaired mobility requiring walker and wheelchair use. Patient reports residing in a Baltimore County hotel for approximately 10 years with limited support outside of spouse, who discontinued employment to provide full-time caregiving and transportation. Patient reports no current household income and is seeking assistance with income/resources, food insecurity, Meals on Wheels, and completion of the Social Security disability application/eligibility process. Patient also reports need for reading glasses. Patient is unclear regarding other home health services ordered by PCP but reports referral to MSW. MSW to assess eligibility and provide appropriate community resource referrals and assistance with benefits navigation.

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/10/2026

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: 09/04/2026	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 **Laura Emmanuel-Allen** 7141 Security Blvd Woodlawn, MD 21044 NPI 1114312352	**Phone Number** **Fax Number**
Physician's Signature and Date Signed **X** **Laura Emmanuel-Allen** 09/04/2026: Date of physician last face-to-face	