Home Health Certification and Plan of Care

Order ID: 1150/20179

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2QG3RR6NX01	06/29/2026	From: 06/29/2026 To: 08/27/2026	27427	217058

6. Patient's Name and Address

Peggy Bowman
1232 Walters Avenue,
BALTIMORE, MD 21239-
443-742-6003

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 04/03/1938 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
F03.90	Unsp dementia unsp severity without beh/psych/mood/anx	06/29/26

13. ICD	Other Pertinent Diagnoses	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	06/29/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/29/26
N18.30	Chronic kidney disease stage 3 unspecified	06/29/26
J44.89	Other specified chronic obstructive pulmonary disease	06/29/26
I82.409	Acute embolism and thombos unsp deep vn unsp lower extremity	06/29/26
H40.9	Unspecified glaucoma	06/29/26
F39.	Unspecified mood [affective] disorder	06/29/26
E78.5	Hyperlipidemia unspecified	06/29/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/29/26
Z87.440	Personal history of urinary (tract) infections	06/29/26

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

Breo Ellipta - Fluticasone Furoate: Vilanterol Trifenatate 50-25 MCG/INH / 1 inhalation inhale by mouth once a day for COPD
Alogliptin Benzoate 25 MG / 1 Tablet by mouth once a day for DM
AMLODIPINE 10 MG / 1 Tablet by mouth one time a day for HTN
Albuterol Sulfate And Ipratropium Bromide - Albuterol Sulfate: Ipratropium Bromide 0.5-2.5 (3) MG/3ML / 3 ml inhale via nebulizer by mouth every 6 hours as needed for SOB
MELATONIN 3 MG / 1 Tablet by mouth at bedtime for Insomnia
MIRALAX Give 17 Gram by mouth one time a day for Constipation
MIRTAZAPINE 7.5 MG / 1 Tablet by mouth one time a day for Depression
MONTELUKAST SODIUM 10 MG / 1 Tablet by mouth in the evening for Asthma
PANTOPRAZOLE DR 40 MG / 1 Tablet by mouth one time a day for GERD
QUETIAPINE FUMARATE 25 MG / 1 Tablet by mouth one time a day for Major Depressive Disorder
Sennosides - Senna 8.6 MG / 1 Tablet by mouth in the evening for BM Regiment
LATANOPROST Ophthalmic Emulsion 0.005 % / Instill 1 drop in both eyes at bedtime for Ocular Hypertension
Proventil-Hfa - Albuterol Sulfate 108 (90 Base) MCG/ACT / 1 puff inhale orally every 6 hours as needed for SOB, Wheezing

14. DME and Supplies:

hospital bed, nebulizer, bath bench, walker

15. Safety Measures:

bathroom safety, standard precautions, supervision at all times, walker precautions, transfer with assist, fall precautions, bleeding precautions, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

low cholesterol, diabetic, low sodium

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Bowel/Bladder Incontinence!Endurance!Dyspnea With Minimal Exertion

18.B. Activities Permitted

Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., 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: Fair

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

SN: patient will be responsible for managing treatment
PT: family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Unspecified dementia unspecified severity without beh/psych/mood/anx, 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 an 88-year-old female admitted to home health services following discharge from a skilled nursing facility (SNF). Her past medical history is significant for asthma, chronic obstructive pulmonary disease (COPD), depression, type 2 diabetes mellitus, insomnia, constipation, chronic kidney disease (CKD) stage 3, glaucoma, gastroesophageal reflux disease (GERD), hyperlipidemia, dementia, recurrent urinary tract infections (UTIs), and a history of falls. The patient was recently hospitalized for a UTI associated with altered mental status before transitioning to SNF rehabilitation. She remains homebound due to generalized weakness, impaired balance, and a history of recurrent falls requiring the use of a front-wheeled walker and one-person assistance for transfers and ambulation, making it a taxing effort for her to leave the home safely. The patient currently resides in an assisted living facility with 24-hour staff available for medication management, supervision, and assistance with activities necessary to maintain safety. She is alert and oriented to person and place, with intermittent orientation to time (A&O x2-3). Her daughter, Carrie, serves as the patient's power of attorney (POA) and actively participates in care planning. The patient's daughter confirmed that primary care follow-up will continue with Dr. Tracy Dodd, and she will schedule the post-discharge appointment. The home health nurse instructed the patient's daughter and assisted living staff regarding the importance of timely follow-up after SNF discharge. The patient's previous provider, Dr. Leonard Mugo, was also identified for continuity of care as needed. During the skilled nursing assessment, the patient reported severe shooting pain in the right leg rated 8/10. She stated that topical analgesic treatment previously administered during her SNF stay was effective in relieving the discomfort. The patient also complained of frequent urination and continues to experience occasional urinary incontinence, requiring the routine use of absorbent pull-up briefs. She has a documented history of depression but is not currently receiving behavioral health therapy. The skilled nurse contacted Dr. Tracy Dodd's office and spoke with Joyce, who relayed the patient's complaints to the provider for further evaluation and treatment recommendations. The patient's daughter also reported that the patient previously utilized a Dexcom continuous glucose monitoring system; however, no active Dexcom order or profile was identified. The daughter will contact the provider to clarify whether continuous glucose monitoring should be resumed. Respiratory assessment revealed no abnormal lung sounds, and the patient denied acute respiratory distress. Nebulizer treatment was administered by the skilled nurse to evaluate complaints of shortness of breath. Oxygen saturation remained stable at 99% before and after treatment without evidence of respiratory compromise. Assisted living staff were instructed regarding proper nebulizer administration and PRN treatment scheduling. Facility staff reported that the patient remains compliant with prescribed medications and inhalation therapy. The patient ambulates with a rolling walker and requires one-person assistance for transfers and short-distance ambulation to reduce fall risk. No open wounds, skin breakdown, or abnormal bleeding were observed during assessment. The patient was instructed on maintaining adequate hydration to reduce the risk of dehydration and recurrent urinary tract infections. The patient also requires a routine ophthalmology evaluation as recommended by the assisted living facility provider due to her history of glaucoma. Physical therapy evaluation was completed and revealed significant functional decline compared to the patient's prior level of function. Prior to hospitalization, the patient lived independently and ambulated with a rolling walker under supervision. At the time of evaluation, she demonstrated bilateral lower extremity weakness with manual muscle testing of approximately 3-/5, requiring minimal assistance for transfers and short-distance ambulation with a rolling walker. Verbal cueing was necessary to promote improved trunk extension and posture during mobility. The patient demonstrates impaired balance, decreased strength, reduced endurance, and diminished functional mobility, placing her at continued high risk for falls. Skilled physical therapy is medically necessary to improve lower extremity strength, balance, gait safety, endurance, and overall functional independence to maximize her return toward her prior level of function. Occupational therapy has also been ordered to address deficits in activities of daily living, safety awareness, and functional independence. Skilled nursing services are ordered at a frequency of one

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/29/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Tracy Dodd
10751 Falls Rd Ste 304
Timonium, MD 21093
PHONE: 4108473535 FAX: 14103672236 NPI: 1639798747

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 : 04/27/2026

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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visit per week for six weeks (1W6) for ongoing cardiopulmonary assessment, medication management, disease process education, pain assessment, fall prevention, coordination of care, and monitoring of the patient's overall clinical status. An evaluation for home health aide services has also been requested to determine the patient's need for assistance with personal care activities.
 Date of Order 06/29/2026 Orders Physician Face-to-Face Date: 04/27/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat, hha-adl's due to Unspecified dementia unspecified severity without beh/psych/mood/anx 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 Dodd, Tracy

SN Careplans

SN WK1: 1 (06/29/26-07/04/26) ,WK2: 1 (07/05/26-07/11/26) ,WK3: 1 (07/12/26-07/18/26) ,WK4: 1 (07/19/26-07/25/26) ,WK5: 1 (07/26/26-08/01/26) ,WK6: 1 (08/02/26-08/08/26)

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

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

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; 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 ; 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.

No open wounds noted
Advance Directive:Carrie Bowman

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, abnormal blood pressure, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal BS < 70/140 > mg/dL, heartburn/indigestion, frequent urination, muscle weakness, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit, balance deficit, pain radiating to arms/legs, loss of appetite

PROCEDURES: Physician order lab work: Written order - Dr. Dodd - Nurse to obtain urine specimen for UA on next visit, cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision: ALF staff, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired: Reader, coordinate/arrange transportation services: Daughter

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, * how to keep home safe for patient with vision

SN Goals

PATIENT-STATED GOAL: To get stronger

GOALS
patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

patient's transportation needs are met

patient is adequately supervised

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/29/2026

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loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (06/29/26-07/04/26) ,WK3: 1 (07/12/26-07/18/26) ,WK5: 1 (07/26/26-08/01/26) ,WK7: 1 (08/09/26-08/15/26) ,WK9: 1 (08/23/26-08/27/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170G1 - Car Transfer, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170D1 - Sit to Stand, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170F1 - Toilet Transfer

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed. Upgrade as tolerated, equipment training, work simplification/energy conservation, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 04. Supervision or touching assistance, Sit to Stand - 04. Supervision or touching assistance, Toilet Transfer - 05. Setup or clean-up assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate 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

PT Goals

PATIENT-STATED GOAL: To be able to walk without help

GOALS

Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Toilet Transfer - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate 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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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