

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1150/21700

Patient Details				
Patient's HI Claim No. 1003323801	Start of Care Date 08/29/2026	Certification Period 08/29/2026 - 10/27/2026	Medical Record No. 29698	Provider No. 217058
Patient's Name and Address Patricia Barr 1600 W Mount Royal Avenue Apt 309 BALTIMORE, MD 21217		Gender Female	Date of Birth 07/01/1957	Phone Number 410-225-9675
		Email		Primary Language English
Clinical Profile				
Provider's Name HomeCentris Healthcare LLC		Address 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117		Phone Number 410-321-8448
NPI 1487113239				Fax Number 410-559-3002
Clinical Condition Requiring Homecare: The patient is a 69-year-old female who is homebound due to chronic respiratory failure requiring continuous supplemental oxygen, congestive heart failure (CHF), type 2 diabetes mellitus, hypertension, schizophrenia, history of falls, and multiple additional comorbidities including rhabdomyolysis, lupus, sleep apnea, gout, anxiety, depression, and obesity. The patient was recently hospitalized following a fall and CHF exacerbation and currently resides alone in an elevator-accessible apartment. She requires an assistive device and human assistance to safely leave the home due to impaired mobility, continuous oxygen dependence, decreased endurance, and increased fall risk. The patient is alert and oriented x3. Skin is dry and intact. She is maintained on continuous oxygen at 3 L/min via nasal cannula, with SpO2 measured at 94%. Lung sounds are diminished in the bilateral lower lobes; however, respirations are even and unlabored, and the patient voiced no acute complaints. Swelling was noted to the feet. The patient reports that she uses supplemental oxygen while inside the home but removes it when leaving the residence; education regarding the importance of following prescribed oxygen therapy and maintaining oxygen use as ordered should be reinforced. Physical therapy evaluation was completed following the patient's recent hospitalization. The patient ambulates on indoor surfaces using a rolling walker and was able to ambulate approximately 30 feet with a limp and weight bearing primarily on the toe of the right foot. She requires supervision for transfers to the toilet, chair, and bedside and supervision for bed mobility. Outdoor mobility, car transfers, and stair negotiation were not assessed during this evaluation. Functional assessment revealed significant mobility limitations and elevated fall risk, as evidenced by a Tinetti score of 12/28. The patient also presents with a right knee flexion contracture measuring approximately 20 degrees from full extension, which further contributes to impaired gait mechanics and functional mobility. During the session, the patient tolerated five repetitions each of hip flexion, bridging, hooking		Physician Statement on Homebound Status: Due to diagnosis of Chronic respiratory failure with hypoxia, 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.		

rotation, straight-leg raises, hip abduction, knee extension, and ankle pumps. Overall, the patient demonstrates decreased lower-extremity strength, impaired balance, limited endurance, abnormal gait mechanics, right knee range-of-motion limitation, and decreased functional mobility following hospitalization. The patient would benefit from continued skilled home health physical therapy to address strength deficits, balance impairment, gait abnormalities, transfer safety, endurance, range of motion, and overall functional mobility. Treatment will focus on progressive therapeutic exercise, gait and transfer training, balance activities, range-of-motion interventions, fall-prevention strategies, and patient education to improve safety and independence with mobility in the home. Continued skilled services are medically necessary due to the patient's significant fall risk, multiple chronic comorbidities, oxygen dependence, recent hospitalization for fall and CHF exacerbation, and limited ability to safely leave the home. The plan of care is directed toward improving functional strength and mobility while maximizing safety and reducing the risk of further falls, rehospitalization, and functional decline.

Date of Order
08/29/2026
Orders
Physician Face-to-Face Date: 08/26/2026
Clinical Condition Requiring Home Care per
Certifying Physician: sn-disease management
pt-eval & treat ot-eval & treat due to Chronic
respiratory failure with hypoxia
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:

Physician
Osei-Boamah, Emmanuel

ICD-10 CM Principal Diagnosis: J96.11. Chronic respiratory failure with hypoxia

Other Pertinent Diagnoses		
ICD-10 CM	Description	Medications
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	Proventil-Hfa - Albuterol Sulfate 2 puffs Inhalation every 6 (six) hours as needed for wheezing for wheezing ZYLOPRIM 100 MG / 1 Tablet by mouth daily Aspirin Ec - Aspirin 81 MG / 1 Tablet by mouth daily LIPITOR 40 MG / 1 Tablet by mouth daily COGENTIN 2 MG tablet by mouth once time daily JARDIANCE 10 MG / 1 Tablet by mouth in the morning FLONASE 50 mcg/actuation nasal spray / 1 spray Nasal daily SYNTHROID 112 MCG / 1 Tablet by mouth daily CLARITIN 10 MG / 1 Tablet by mouth in the morning TOPROL-XL 24 hr 25 MG / 1 Tablet by mouth daily PROTONIX 40 MG / 1 Tablet by mouth daily TRILAFON 16 Mg tablet by mouth once daily
I50.20	Unspecified systolic (congestive) heart failure	
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	
N18.30	Chronic kidney disease stage 3 unspecified	
M62.82	Rhabdomyolysis	
L93.1	Subacute cutaneous lupus erythematosus	
G47.33	Obstructive sleep apnea (adult) (pediatric)	
M10.9	Gout unspecified	
E78.00	Pure hypercholesterolemia unspecified	
F20.0	Paranoid schizophrenia	
F41.9	Anxiety disorder unspecified	
F32.A	Depression unspecified	
E03.9	Hypothyroidism unspecified	

K21.9	Gastro-esophageal reflux disease without esophagitis	
E07.9	Disorder of thyroid unspecified	
E66.813	Other obesity	
Z87.440	Personal history of urinary (tract) infections	
Z79.84	Long term (current) use of oral hypoglycemic drugs	
Z79.82	Long term (current) use of aspirin	
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: 0. Never, SOCIAL ISOLATION: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes
Functional Limitations Dyspnea With Minimal Exertion, Ambulation		Activities Permitted Walker
DME & Supplies bath bench, walker		Safety Measures fall precautions, hand rails, ambulates with device, standard precautions, walker precautions
Nutrition low sodium, regular, 2gm sodium		Allergies hydroxychloroquine penicillin
Barr, Patricia Cert Period 08/29/26 - 10/27/26		

Advance Directives No Advance Directive	Caregiver Status 0. No assistance needed - patient is independent or does not have needs in this area; 0. No assistance needed - patient is independent or does not have needs in this area
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.	DISCHARGE PLAN: patient will be responsible for managing treatment
Orders for Discipline and Treatment: 1 - SOC - SN PT Eval OT Eval	
SN CAREPLAN SN frequency WK1: 1 (08/29/26-08/29/26),WK2: 1 (08/30/26-09/05/26),WK3: 1 (09/06/26-09/12/26),WK4: 1 (09/13/26-09/19/26),WK5: 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, O2 saturation < 88 > 100, pain < 0 > 5 CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance HOSPITALIZATION RISKS: 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. ; 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 08/29/2026 Problems : M1720 - Anxiety M1400 - Dyspnea M2020 - Oral Med Management swelling in the arms/legs swelling in the arms/leas	SN NARRATIVE Patient is homebound status due to chronic respiratory failure with contious use of oxygen, hx of falls, Dm 2,HTN, schizophrenia leaving the home patient is at increase risk for falls. Patient ambulates with an assistive device and continious oxygen use and requires human assistance when leaving the home for safety.Patient alert and orient x 3 .Skin dry and intact. Patient on continiou oxygen SpO2 94%on 3LNC. Lung sounds diminished right and left lower lobes. Respiration even and unlabored.Swelling noted to feet. NO complaints voiced. ----- Patient has chronic respiratory failure with contious use of oxygen, hx of falls, Dm 2,HTN, schizophrenia .Patient ambulates with an assistive device and continious oxygen.Patient alert and orient x 3 .Skin dry and intact. Patient on continiou oxygen SpO2 94%on 3LNC. Lung sounds diminished right and left lower lobes. Respiration even and unlabored.Swelling noted to feet. NO complaints voiced. SN GOALS PATIENT-STATED GOAL: Get my legs and feet better to walk better 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 * 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 * depression-prevention strategies including avoidance of isolation * healthy eating * sleeping habits * identification of activities that bring pleasure * preventive care * recalls related medication(s) purpose, schedule patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule patient is adequately supervised caregiver performs medical/rehabilitation treatments with adequate competence patient/caregiver recalls * how to keep home safe for patient with vision loss including eliminating hazards * enhancing lighting * using mechanical aids meal preparation is available to patient for all meals

swelling of affected area swelling of affected area obesity obesity rough/scaly/cracked skin swell/redness surround. skin B1000 - Vision Deficit meal preparation meal preparation D0160 - Depression D0160 - Depression M2102f - Patient Supervision M2102f - Patient Supervision M2102d - Caregiver Performs Treatment M2102d - Caregiver Performs Treatment PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired 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, * 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence	
	OT NARRATIVE Patient is a 67 year old woman who was recently discharged from the hospital secondary to acute respiratory failure with hypoxia. She has a past medical history of HTN, HLD, Heart failure, chronic respiratory failure on 3L of O2. OSA, gout, CKD and schizophrenia. Patient lives alone in a one bedroom apartment and gets some assistance from family. She is ambulatory using her rolling walker with standby assistance. She is standby assistance for sit to stand transfers and toilet transfers. She is bathing sink side and has difficulty bathing in the shower. She is contact guard/standby assistance for sit to stand transfer and toilet transfers using compensatory strategies. Patient demonstrates weakness of bilateral upper extremity muscle strength 3+/5 manual muscle testing. Patient has difficulty with house cleaning secondary to endurance. ----- Patient is a 67 year old woman who was recently discharged from the hospital secondary to acute respiratory failure with hypoxia. She has a past medical history of HTN, HLD, Heart failure, chronic respiratory failure on 3L of O2. OSA, gout, CKD, DM and schizophrenia. Patient lives alone in a one bedroom apartment and gets some assistance from family. She is ambulatory using her rolling walker with standby assistance. She is standby assistance for sit to stand transfers and toilet transfers. She is bathing sink side and has difficulty bathing in the shower. She is contact guard/standby assistance for sit to stand transfer and toilet transfers using compensatory strategies. Patient demonstrates weakness of bilateral upper extremity muscle strength 3+/5 manual muscle testing. Patient has difficulty with house cleaning secondary to endurance.
Barr, Patricia Cert Period 08/29/26 - 10/27/26	

PT CAREPLAN PT frequency WK2: 1 (08/30/26-09/05/26),WK3: 1 (09/06/26-09/12/26),WK4: 1 (09/13/26-09/19/26),WK5: 1 (09/20/26-09/26/26) 08/31/2026 Problems : GG0170G1 - Car Transfer GG0130F1 - Upper Body Dressing GG0130H1 - Don/Doff Footwear GG0130G1 - Lower Body Dressing GG0130E1 - Shower/Bathe Self GG0130C1 - Toileting Hygiene GG0130B1 - Oral Hygiene GG0170L1 - Walk 10 ft on Uneven Surface GG0170E1 - Chair to Bed to Chair 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: home exercise program: Quad sets, short arc quads, hip flexion, bridging, standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, equipment training, gait training/stair training, transfers training TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, 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, Upper Body Dressing - 06. Independent	PT NARRATIVE Ambulates on indoor surface of apartment with rolling walker 160 feet x 2 with distant supervision. . Declined ambulation in building hallway. Tolerates 15 reps of therex sitting, supine and standing with cues for technique. States she has not been out of her apartment since she has been home. Reports she sees her doctor next week. Transfers sit to stand from bed, chair or toilet independent. Client did not use oxygen during visit today. Tinetti from 12 to 16/28 and Tug 56 to 28 seconds. ----- Ambulates on indoor surface of apartment with rolling walker 160 feet x 2 with distant supervision. . Declined ambulation in building hallway. Tolerates 15 reps of therex sitting, supine and standing with cues for technique. States she has not been out of her apartment since she has been home. Reports she sees her doctor next week. Transfers sit to stand from bed, chair or toilet independent. Client did not use oxygen during visit today. Tinetti 12 to 16 /28. Plan to progress with gait and therex. PT GOALS PATIENT-STATED GOAL: To be able to get around the house by myself without my cane GOALS Toilet Transfer - 06. Independent Shower/Bathe Self - 05. Setup or clean-up assistance Sit to Stand - 05. Setup or clean-up assistance Chair to Bed to Chair - 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 Walk 150 Feet - 04. Supervision or touching assistance 1 - Step (curb) - 04. Supervision or touching assistance Picking Up Object - 04. Supervision or touching assistance Car Transfer - 05. Setup or clean-up assistance Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Upper Body Dressing - 06. Independent
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Signature and Date of Verbal SOC Where Applicable: Electronically signed by: Charles Messick RN on 09/23/2026	
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: 08/26/2026	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 Emmanuel Osei-Boamah 3900 Loch Raven Blvd Baltimore, MD 21218 NPI 1639282460	Phone Number 4105005500 Fax Number 14106595691
Physician's Signature and Date Signed X Emmanuel Osei-Boamah, MD 08/26/2026: Date of physician last face-to-face	

