FAX COVER PAGE

HomeCentris HEALTHCARE
HOME-CENTRIC HEALTHCARE STRATEGIES

Date: 11/10/2026

To:
Geneva Cason , NP

From:
HomeCentris Healthcare LLC
10 Crossroads Drive, Suite 102
Owings Mills, MD 21117-8284

Phone: 410-321-8448

Fax: 410-559-3002

Subject:
Form Submission

Memo:

Please review the attached document.

URGENT: Please review and respond to this fax transmission promptly.

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1150/23104

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
7VM5FV2GT82	11/02/2026	11/02/2026 - 12/31/2026	32186	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Virginia Garrison 230 Doncaster Road Joppa, MD 21085	Female	06/23/1948	410-960-0480
	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 78-year-old female referred to home health services following a recent hospitalization and subsequent subacute rehabilitation stay for pyelonephritis, complicated urinary tract infection (UTI), and atrial fibrillation. Her medical history is significant for paroxysmal atrial fibrillation managed with apixaban, hypertension, hyperlipidemia, depression, iron-deficiency anemia, peripheral neuropathy, ambulatory dysfunction, diabetes mellitus, congestive heart failure, chronic kidney disease, obstructive sleep apnea, anxiety, morbid obesity, bilateral total knee replacements, and history of colon cancer status post partial colectomy with left lower-quadrant colostomy placement. She initially presented to the emergency department with nausea, vomiting, foul-smelling urine, profound generalized weakness, and decreased ostomy output lasting approximately 3-4 days. She also reported an inability to stand or ambulate for approximately one week before hospitalization. During her hospital stay, she developed clinical sepsis secondary to complicated right-sided pyelonephritis/UTI and was treated with intravenous antibiotics. Following hospitalization, she was transferred to a rehabilitation facility and has since returned home. She was discharged on oral cefdinir 300 mg every 12 hours for seven days and is currently completing the final dose of the prescribed antibiotic course. The patient resides in a split-level home with nine steps to enter and an additional five steps leading to the main living area, with railings available for support. The home environment was noted to be cluttered and unclean during the assessment. The patient was found soiled, and assistance was provided with personal hygiene and changing into clean clothing. She currently sleeps in a recliner and performs bathing at the kitchen sink using soap and water while alternating between seated and standing positions. She has a left lower-quadrant colostomy, which she independently manages and changes, and reports bowel incontinence as well as urinary incontinence, for which she wears adult briefs. She denies pain at the time of assessment but reports occasional left

Physician Statement on Homebound Status:

Due to diagnosis of Pyonephrosis, 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.

shoulder discomfort. She ambulates very slowly using a rollator or rolling walker and experiences significant fatigue and shortness of breath after walking only a few steps. Physical therapy evaluation revealed significant generalized and bilateral lower extremity weakness, impaired balance, decreased endurance, and substantial limitations in functional mobility. The patient demonstrated a Tinetti score of 7/28, indicating a high risk for falls. Sit-to-stand transfers require maximum assistance from one person, while stand-pivot transfers require moderate assistance using a rolling walker. Ambulation with a rolling walker requires moderate assistance, with a wide base of support, decreased heel strike, and frequent initial contact on the forefoot. Her activity tolerance is poor, with exertional dyspnea and significant fatigue during minimal physical activity. These impairments substantially limit her ability to safely perform transfers, ambulate within the home, and negotiate the multiple steps required to access her residence. She demonstrates fair rehabilitation potential and would benefit from skilled physical therapy to address lower extremity weakness, impaired balance, gait abnormalities, transfer dependence, and decreased cardiopulmonary endurance. Occupational therapy evaluation revealed bilateral upper extremity strength of 5/5 throughout the shoulders, elbows, wrists, and grip. The patient was pleasant, cooperative, and motivated, tolerating the evaluation well with minimal verbal cueing. She currently completes her self-care routine at her reported baseline with modified independence and performs functional mobility using a two-wheeled walker with supervision to setup assistance. She independently manages her colostomy and medications and reports no difficulties with her medication regimen or medication-related side effects. Her personal goal is to improve lower extremity strength. Based on the evaluation, the patient does not demonstrate additional occupational therapy needs at this time, as she is functioning at her baseline level for self-care activities. Occupational therapy services are therefore not indicated currently. Medication review was completed, and the patient was instructed to complete the prescribed cefdinir course as directed. Given her history of atrial fibrillation and current apixaban therapy, continued medication compliance and monitoring for potential bleeding complications are important. Skilled nursing follow-up should include monitoring for recurrent urinary symptoms, fever, worsening weakness, changes in urine characteristics, and other signs of infection or sepsis. Additional assessment should address colostomy function and output, hydration status, bowel and bladder management, skin integrity, and the patient's overall nutritional and functional status. Fall prevention education, safe walker use, transfer techniques, energy conservation, and the importance of requesting assistance with mobility were reinforced. The patient is considered homebound due to profound

generalized weakness, impaired balance, poor endurance, exertional dyspnea, and significant dependence on assistance and an assistive device for safe mobility. Her Tinetti score of 7/28 further demonstrates substantial fall risk. Negotiating the multiple steps required to enter and access her home presents considerable difficulty and requires significant assistance and taxing effort. Continued skilled physical therapy is medically necessary to improve lower extremity strength, balance, gait safety, transfer ability, and functional endurance while reducing the risk of falls and further functional decline. Ongoing skilled nursing assessment is also warranted to monitor recovery following sepsis and pyelonephritis, evaluate cardiopulmonary status and medication management, and identify potential complications associated with her multiple chronic conditions. The overall plan of care is directed toward improving safety, preventing rehospitalization, maximizing functional mobility, and promoting the highest achievable level of independence within the home.

Date of Order
11/02/2026
Orders
Physician Face-to-Face Date: 10/26/2026
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Pyonephrosis
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
Cason, Geneva

ICD-10 CM Principal Diagnosis: N13.6. Pyonephrosis

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
I48.0	Paroxysmal atrial fibrillation	ACETAMINOPHEN 325 MG Tablet / Give 2 tablet by mouth as necessary every 6 hours for Pain ASCORBIC ACID 500 MG Tablet / Give 2 tablet by mouth one time a day for Vitamin C Deficiency Atorvastatin Calcium - Atorvastatin Calcium 20 MG / 1 Tablet by mouth in the evening for High Cholesterol Bisoprolol Fumarate And Hydrochlorothiazide - Bisoprolol Fumarate: Hydrochlorothiazide 10-6.25 MG / 1 Tablet by mouth one time a day for HTN CYANOCOBALAMIN 1000 MCG / 1 Tablet by mouth one time a day for Vitamin B12 Deficiency ELIQUIS 5 MG / 1 Tablet by mouth two times a day for AFib Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) MG / 1 Tablet by mouth once a day for Anemia Escitalopram Oxalate - Escitalopram Oxalate 10 MG / 1 Tablet by mouth one time a day for Depression FLORASTOR 250 MG / 1 Capsule by mouth twice a day for UTI Prophylaxis for 10 Days GABAPENTIN 200 MG / 1 Capsule by mouth two times a day for Neuropathic pain Magnesium Oxide - Simethicone 400 MG / 1 Tablet by mouth one time a day for Magnesium Deficiency MELATONIN 5 MG / 1 Tablet by mouth every 24 hours as needed for insomnia MULTIPLE VITAMIN 0 Give 1 tablet by mouth one time a day for Vitamin Deficiency
L89.152	Pressure ulcer of sacral region stage 2	
L89.313	Pressure ulcer of right buttock stage 3	
L89.323	Pressure ulcer of left buttock stage 3	
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	
I50.32	Chronic diastolic (congestive) heart failure	
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	
N18.31	Chronic kidney disease stage 3a	
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	
E78.5	Hyperlipidemia unspecified	
F32.A	Depression unspecified	
D50.9	Iron deficiency anemia unspecified	
G47.33	Obstructive sleep apnea (adult) (pediatric)	
E60.	Dietary zinc deficiency	
E87.5	Hyperkalemia	

F41.9	Anxiety disorder unspecified
G47.00	Insomnia unspecified
N94.9	Unsp cond assoc w female genital organs and menstrual cycle
R73.03	Prediabetes
R91.1	Solitary pulmonary nodule
E66.01	Morbid (severe) obesity due to excess calories
Z79.01	Long term (current) use of anticoagulants
Z96.653	Presence of artificial knee joint bilateral
Z96.641	Presence of right artificial hip joint
Z93.3	Colostomy status
Z90.49	Acquired absence of other specified parts of digestive tract
Z85.038	Personal history of malignant neoplasm of large intestine

Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50 MCG (2000 UT) / 1 Capsule by mouth one time a day for Vitamin D3 Deficiency
Cefdinir - Cefdinir 300 mg Take 1 tablet by mouth every 12 hours For UTI for 7 days

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: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes
Functional Limitations Bowel/Bladder Incontinence, Endurance, Ambulation, Dyspnea With Minimal Exertion	**Activities Permitted** Walker
DME & Supplies 4 wheeled walker, rolling walker, walker	**Safety Measures** ambulates with device, anticoagulant precautions, bathroom safety, bleeding precautions, fall precautions, medication safety, standard precautions, walker precautions
Nutrition low sodium	**Allergies** adhesive tape

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

Caregiver Status
0. No assistance needed - patient is independent or does not have needs in this area; 1. Non-agency caregiver(s) currently provide assistance

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.

DISCHARGE PLAN:
SN: patient will be responsible for managing treatment
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

OT Eval

PT Eval

SN CAREPLAN

SN frequency WK1: 1 (11/02/26-11/07/26),WK2: 1 (11/08/26-11/14/26),WK3: 1 (11/15/26-11/21/26),WK4: 1 (11/22/26-11/28/26),WK5: 1 (11/29/26-12/05/26)

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: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

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
Advance Directive:Durable power of attorney for health care/Medical power of attorney

11/04/2026 Problems : abnormal BS < 70/140 > mg/dL (EM)
#1 - GI Ostomy - Anterior Left Abdomen - COLOSTOMY pouch in place.
M1600 - UTI
M1610 - Urinary Incontinence
M1033 - Exhaustion
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
abnormal blood pressure
balance deficit
limited strength
muscle weakness
frequent urination
open sores/lesions
meal preparation

PROCEDURES: physician-ordered wound care: #1 - GI Ostomy - Anterior Left Abdomen - COLOSTOMY pouch in place.: Colostomy care done by patient, cough/deep breathing exercises, glucose testing via monitor, apply collection/fistula pouch, ostomy care & irrigation, bladder training

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * 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 incorporate lifestyle modifications to optimize renal condition including renal-specific diet exercise monitoring of blood pressure blood sugar home, related medication(s) purpose, schedule remedies, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * how to minimize chemotherapy and radiation side-effects including management of nausea or vomiting diarrhea appetite loss hair loss fatigue insomnia, related medication(s) purpose, schedule, * ostomy management including how to clean stoma change ostomy pouch, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to

SN NARRATIVE

The patient is a 78-year-old female with a history of paroxysmal atrial fibrillation on apixaban, hypertension, hyperlipidemia, depression, iron-deficiency anemia, peripheral neuropathy, ambulatory dysfunction, prior colon cancer status

post partial colectomy with subsequent left lower-quadrant colostomy, and morbid obesity. She presented to the emergency room for nausea and vomiting, foul-smelling urine, and profound generalized weakness. She also reported being unable to stand or ambulate for approximately one week prior to presentation. She also reported decreased ostomy output for approximately 3-4 days. During hospitalization, she developed clinical sepsis attributed to complicated right-sided pyelonephritis/UTI and was treated with IV antibiotics. She was transferred to a rehabilitation and is home now with PO Cefdinir 1 tablet 300mg Q12 hours X 7 days. and its on her last dose. She has a colostomy which she changes by herself. She is incontinent of bladder and uses adult depends. She denies pain at the moment but reports occasional left shoulder pain. She ambulates very slowly with a rollator. She is so weak that walking few steps makes her very tired.

SN GOALS

PATIENT-STATED GOAL: To get up and walk and go up and down the stairs easier.

GOALS
patient/caregiver recalls
* how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet
* exercise
* monitoring of blood pressure
* blood sugar
* home
* recalls related medication(s) purpose, schedule remedies

patient/caregiver recalls
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* ostomy management including how to clean stoma
* change ostomy pouch
* 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

promote acidic bladder environment (cranberry juice) perineal hygiene, 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, meal preparation is available to patient for all meals

* how to minimize chemotherapy and radiation side-effects including management of nausea or vomiting
* diarrhea
* appetite loss
* hair loss
* fatigue
* insomnia
* 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/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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

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

meal preparation is available to patient for all meals

OT CAREPLAN
OT frequency WK1: 1 (11/02/26-11/07/26)

11/04/2026 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: cough/deep breathing exercises, incentive spirometer, home exercise program, equipment training, work simplification/energy conservation, gait training/stair training, transfers training

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, 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, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 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 - 02. Substantial/maximal assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT NARRATIVE
78 year old female patient with medical history including: paroxysmal atrial fibrillation on apixaban, hypertension, hyperlipidemia, depression, and iron-deficiency anemia. Patient is sleeping in her recliner couch nightly. Patient is bathing at kitchen sink seated and standing using soap and water. Patient is incontinent of bladder and bowel and is urinating in a brief and manages her colostomy independently. Patient completes functional mobility using a two-wheeled walker. Patient completes her self care routine, Modified Independent and functional mobility using a two wheeled walker with Supervision to Setup Assist. Patient completed Bilateral Manual Muscle test and demonstrated 5/5 Bilateral Upper Extremity strength at shoulders elbows, wrists and grasp. Patient's personal goals is that she wants to increase her leg strength. Patient was pleasant and motivated and tolerated Occupational Therapy Evaluation well with Min verbal cues throughout. Patient manages her medications with no difficulties with side effects or regimen. Patient completed her self care routine at her baseline. Patient does not require occupational therapy services at this time.

OT GOALS
PATIENT-STATED GOAL: Patient wants her leg to get stronger.

GOALS
Toilet Transfer - 06. Independent

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

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

4 Steps - 04. Supervision or touching assistance

12 Steps - 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 - 02. Substantial/maximal assistance Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent

PT CAREPLAN

PT frequency WK1: 1 (11/02/26-11/07/26),WK2: 2 (11/08/26-11/14/26),WK3: 1 (11/15/26-11/21/26),WK4: 1 (11/22/26-11/28/26),WK5: 1 (11/29/26-12/05/26),WK6: 1 (12/06/26-12/12/26),WK7: 1 (12/13/26-12/19/26),WK8: 1 (12/20/26-12/26/26)

11/06/2026 Problems : GG0170L1 - Walk 10 ft on Uneven Surface
GG0170E1 - Chair to Bed to Chair
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170E1 - Chair to Bed to Chair
GG0170P1 - Picking Up Object
GG0170P1 - Picking Up Object
GG0170O1 - 12 Steps
GG0170O1 - 12 Steps
GG0170N1 - 4 Steps
GG0170N1 - 4 Steps
GG0170M1 - 1 - Step (curb)
GG0170M1 - 1 - Step (curb)
GG0170D1 - Sit to Stand
GG0170K1 - Walk 150 Feet
GG0170K1 - Walk 150 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170J1 - Walk 50 ft with 2 Turns
GG0170I1 - Walk 10 Feet
GG0170I1 - Walk 10 Feet
GG0170G1 - Car Transfer
GG0170F1 - Toilet Transfer
GG0170F1 - Toilet Transfer
GG0170D1 - Sit to Stand

PROCEDURES: Medication management : Review medication with pt, home exercise program: SeatedKnee extension, heelraises, hip flexion, hip abduction, DF, hamstring curls ALL3X10, dynamic standing balance exercises: Work on exercises with wt shifting and reaching outside bos all directions to improve stability., gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 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, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT NARRATIVE

Physical therapy evaluation completed this day. Patient referred to home health services following recent hospital and subacute rehab. Stay following admission for diagnosis of pionephrosis. And atrial fibrillation. past, medical history significant for diabetes, congestive heart failure. Chronic kidney disease, hyperlipidemia, obstructive sleep apnea, anxiety, depression, obesity, bilateral turtle, knee replacement: cancer, with resection, colostomy placement ulcer on buttocks patient lives in split level home. Nine steps to enter with railing 5 steps up to main floor home is cluttered and dirty pt was soiled assisted pt getting cleaned up and changed. Presents with impaired balance as evidenced by tinetti score of 7 /28, marked le weakness amb with rw mod a with wide bos lacks heelstrike often landing FF. Sit to stand max ax1 spt mod ax1 with rw, low endurance gets experienced dyspnea with activity. Pt has fair potential to benefit from skilled physical therapy to address above listed deficits

PT GOALS

PATIENT-STATED GOAL: Pt stated to improve my strength and walking get up and down the steps to exit the home

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

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

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 11/02/2026

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: 10/26/2026

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 **Geneva Cason**
2945 Emmorton #196
Abington, MD 21009
NPI 1063787422

Phone Number 4433713305

Fax Number 1 9498638542

Physician's Signature and Date Signed

X

Geneva Cason, NP
10/26/2026: Date of physician last face-to-face