Home Health Certification and Plan of Care

Order ID: 1150/11699

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
48202694600	08/26/2025	From: 08/26/2025 To: 10/24/2025	14966	217058

6. Patient's Name and Address
William Barnes
3318 Ingleside Ave,
BALTIMORE, MD 21215-
443-423-3188

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 03/24/1953 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
J44.89	Other specified chronic obstructive pulmonary disease	08/26/25

13. ICD	Other Pertinent Diagnoses	Date
T20.04XD	Burn of unspecified degree of nose (septum) subs encntr	08/26/25
T20.02XD	Burn of unspecified degree of lip(s) subsequent encounter	08/26/25
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	08/26/25
D64.9	Anemia unspecified	08/26/25
F17.210	Nicotine dependence cigarettes uncomplicated	08/26/25
M19.90	Unspecified osteoarthritis unspecified site	08/26/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	08/26/25
Z99.81	Dependence on supplemental oxygen	08/26/25

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

Albuterol Sulfate - Albuterol Sulfate 2.5 MG/0.5ML , 0.5 ml inhale inhalant every 4 hours 4 hours as needed for SOB/Wheezing
Alprazolam - Alprazolam t 0.5 MG , Give 1 tablet by mouth four times a day for anxiety for 3 Days
Buprenorphine Hydrochloride - Buprenorphine Hydrochloride 8 Mg, Give 1 tablet sublingual once a day
Buspirone Hcl - Buspirone Hydrochloride 5 MG ,Give 1 tablet by mouth twice a day
Folic Acid - Folic Acid 1 MG Give 1 tablet by mouth once a day
Gabapentin - Gabapentin 100 MG Give 1 capsule by mouth at bedtime
Ipratropium - Ipratropium Bromide 0.5-2.5 (3) MG/3ML 3 ml inhale inhalant every 6 hours
Mirtazapine - Mirtazapine 30 MG Give 1 tablet by mouth at bedtime
Montelukast Sodium - Montelukast Sodium 10 MG , Give 1 tablet by mouth once a day
Pioglitazone Hydrochloride - Pioglitazone Hydrochloride 30 Mg, Give 1 tablet by mouth once a day
Pantoprazole Sodium - Pantoprazole Sodium 20 MG , Give 2 tablet by mouth once a day
Sertraline Hcl - Sertraline Hydrochloride 50 MG Give 1 tablet by mouth once a day
Fluticasone - Fluticasone Furoate 100-62.5-25 MCG/ACT , 1 puff inhale inhalant once a day
Metformin Hcl - Metformin Hydrochloride 500 MG,Give 1 tablet by mouth once a day DM
Oxygen - Oxygen 3-4 LPM nasal cannula continuous
Quetiapine Fumarate - Quetiapine Fumarate 50 mg 50 MG , Give 1 tablet by mouth at bedtime
Bacitracin Zinc Ointment 2% 2% topical once a day and as needed to burns
Nicorette - Nicotine Polacrilex eq 2 mg base by mouth every 2 hours Take 1 gum by mouth every 2 hrs as needed for smoking cessation
Advil - Ibuprofen 200 mg by mouth every 4 hours Take two tablets every 4 to 6 hrs as needed for pain.

14. DME and Supplies:
bath bench, commode, oxygen supplies, walker, wheelchair, cane

15. Safety Measures:
walker precautions, wheelchair precautions, medication safety, fall precautions, precautions, supervision at all times, standard precautions, bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:
diabetic

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Up As Tolerated, Cane, Walker, Wheelchair

19. Mental & Pyschosocial 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

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: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

22.B.Discharge Plans
patient will be responsible for managing treatment
another facility/provider will be responsible for managing treatment

Homebound status:
Due to diagnosis of Other Specified Chronic Obstructive Pulmonary Disease , 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.

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 08/26/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Priya Srinivas
9091 Snowden River Pkwy # 1085
Columbia, MD 21046
PHONE: 2405479524 FAX: 14432320693 NPI: 1811445745

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 : 08/15/2025

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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Clinical Condition Requiring Homecare:

The patient is a 72-year-old male with a significant past medical history of COPD, hypertension, diabetes mellitus, and arthritis who was recently hospitalized following facial and left ear burns sustained from smoking while using supplemental oxygen. The burns occurred approximately two weeks ago, and the patient underwent hospital evaluation with initiation of daily topical antibiotic ointment application to the affected areas. Current wound care involves applying ointment to maintain moisture and soften the hardened skin, with instructions provided on infection prevention and burn management. Pain is reported at 4/10 localized to the face and ear. No other wounds are present, and no abnormal bleeding has been observed. The patient denies vision changes, abdominal discomfort, urinary symptoms, or recent falls. Last bowel movement was today. The patient resides in an assisted living facility (ALF) with 24-hour staffing for medication administration, ADL support, and supervision. He reports cessation of smoking due to safety concerns. He remains in good spirits and expresses motivation to return to his adult day program once wound healing is sufficient. <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-14 CE-FMS-Oxygen">Oxygen</mh> is administered via nasal cannula at 3 L/min. Lung sounds are clear to auscultation bilaterally with no adventitious sounds. The patient exhibits significant total body tremors, which he states have been lifelong, though he has not previously been evaluated by a neurologist. He requires an assistive device and supervision for safe ambulation and utilizes a stair lift within the facility for mobility. From a functional standpoint, the patient currently requires contact guard assistance for upper and lower body dressing, bathing with a bath bench, sit-to-stand transfers, and toilet transfers, with verbal cueing needed for limb placement. He demonstrates generalized weakness with bilateral upper extremity muscle strength at 4/5. Ambulation tolerance is limited by weakness and dyspnea, requiring contact guard assistance for mobility. Prior to hospitalization, he was able to ambulate with supervision and utilized a chair lift for stair negotiation. Physical therapy evaluation has been completed. The patient presents with decreased strength, impaired balance, and reduced activity tolerance, placing him at increased fall risk and limiting independence with functional mobility. Skilled physical therapy services are recommended to improve strength, enhance safety, and promote a safe return to prior level of function. Nursing services have been initiated for wound care management, infection prevention, and medication education. Patient and ALF staff were educated on medication actions, side effects, and wound care instructions, with verbalized understanding. The care plan includes continued wound care, reinforcement of infection prevention strategies, education on oxygen safety, and progression of skilled PT and OT services to address functional deficits and support independence in ADLs and IADLs.
 Date of Order 08/26/2025 Orders Physician Face-to-Face Date: 08/15/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management PT- eval &treat OT eval &treat due to Other Specified Chronic Obstructive Pulmonary Disease 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: PT Eval Notes: OT Eval Notes: Physician Srinivas, Priya

SN Careplans

SN WK1: 1 (08/26/2025 - 08/30/2025), WK2: 1 (08/31/2025 - 09/06/2025), WK3: 1 (09/07/2025 - 09/13/2025), WK4: 1 (09/14/2025 - 09/19/2025)

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: 3. Multiple hospitalizations (2 or more) in the past 6 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 the pt's incision and on post op day 12-14 the nurse or physical therapist will remove the patient's staples and leave OTA., 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, SpO_2: 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.

apply ABX ointment to burns daily and as needed to prevent infection
Advance Directive:Durable power of attorney for health care/Medical power of attorney

SN Goals

PATIENT-STATED GOAL: to go back adult day progrm

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
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* 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
* how to manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* 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
* 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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	08/26/2025

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PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, heartburn/indigestion, limited endurance, muscle weakness, muscle spasms, Pain Interference with Therapy activities, balance deficit, involuntary movement of extremity, extremity burn/tingle/numb, Pain Interference with ADLs, Pain Effect on Sleep, #1 - Burn - Anterior Right Face - burns to face and left ear, #2 - Burn - Anterior Left Face - burn to face and left ear

PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: apply ABX ointment to burns daily and as needed to prevent infection, coordinate/arrange preparation of missing meals

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, * 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 achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * how to manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, 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

meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (08/26/2025 - 08/30/2025), WK2: 1 (08/31/2025 - 09/06/2025), WK3: 1 (09/07/2025 - 09/13/2025), WK4: 1 (09/14/2025 - 09/19/2025)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object

PROCEDURES: Medication Review- : medications reviewed with patient/caregiver, cough/deep breathing exercises, strengthening exercises, gait training on uneven surfaces, 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 - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 1 - Step (curb) - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Medication Review

PT Goals

PATIENT-STATED GOAL: To be able to walk around normally

GOALS
Chair to Bed to Chair - 06. Independent

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 - 06. Independent

Car 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

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

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

Picking Up Object - 04. Supervision or touching assistance

Medication Review

OT Careplans

OT WK1: 1 (08/26/2025 - 08/30/2025), WK2: 1 (08/31/2025 - 09/06/2025), WK3: 1 (09/07/2025 - 09/13/2025), WK4: 1 (09/14/2025 - 09/19/2025)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene

PROCEDURES: ADLS , Patient/caregiver recalls related purpose and schedule of medications: Medication review , work simplification/energy conservation, transfers training, therapeutic exercises

TEACH PATIENT/CAREGIVER: Oral Hygiene - 06. Independent, Lower Body Dressing - 05. Setup or clean-up assistance, Shower/Bathe Self - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 05. Setup or clean-up assistance, Patient will demonstrate improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

OT Goals

PATIENT-STATED GOAL: Wants to get stronger and better

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

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

Toileting Hygiene - 06. Independent

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

Patient will demonstrate improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	08/26/2025