Home Health Certification and Plan of Care

Order ID: 1150/11073

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3U27VE9EK39	07/01/2025	From: 07/01/2025 To: 08/29/2025	14569	217058

6. Patient's Name and Address
Abraham Ortiz
311 Lord Byron Ln Apt T4,
COCKEYSVILLE, MD 21030-
202-300-4141

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 10/19/1956 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
F10.131	Alcohol abuse with withdrawal delirium	07/01/25

13. ICD	Other Pertinent Diagnoses	Date
K29.20	Alcoholic gastritis without bleeding	07/01/25
I10.	Essential (primary) hypertension	07/01/25
K76.0	Fatty (change of) liver not elsewhere classified	07/01/25
F32.4	Major depressv disorder single episode in partial remis	07/01/25
F41.8	Other specified anxiety disorders	07/01/25
E78.5	Hyperlipidemia unspecified	07/01/25
E53.8	Deficiency of other specified B group vitamins	07/01/25
E44.0	Moderate protein-calorie malnutrition	07/01/25
F43.10	Post-traumatic stress disorder unspecified	07/01/25
Z87.891	Personal history of nicotine dependence	07/01/25

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

Gabapentin - Gabapentin 400 Mg, Take 1 capsule by mouth three times a day
Magnesium Oxide - Simethicone 400(240mg), Take 1 tablet by mouth twice a day
Melatonin - Melatonin 3mg by mouth at bedtime For sleep
Nifedipine Er - Nifedipine 90mg by mouth once a day Blood pressure
Vitamin B12 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000 mcg, take 1 tablet by mouth once a day
Folic Acid - Folic Acid 1 Mg, Take 1 tablet by mouth once a day
Lisinopril - Lisinopril 20 Mg, Take 1 tablet by mouth once a day
Vitamin B-1 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 100mg by mouth once a day
Pantoprazole - Pantoprazole Sodium 40 mg, Take 1 tablet by mouth once a day GERD
Hctz - Hydralazine Hydrochloride: Hydrochlorothiazide 12.5mg by mouth once a day Blood pressure
Hydroxyzine Hydrochloride - Hydroxyzine Hydrochloride 10 mg 10 Mg, Take 1 tablet by mouth three times a day Anxiety per patient

14. DME and Supplies:
rolling walker

15. Safety Measures:
walker precautions, fall precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

22. A 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.

22.B.Discharge Plans
patient will be responsible for managing treatment
patient will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Due to Alcohol abuse with withdrawal delirium, 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 a 68-year-old male with a past medical history significant for hypertension, depression, alcohol use, gastrointestinal bleeding, and cocaine use. He was recently hospitalized for alcohol withdrawal and is now receiving home health services. He is alert and oriented ×4 and reports bilateral lower extremity (BLE) pain rated at 10/10. On assessment, both feet are edematous with overgrown toenails; referral to podiatry is recommended. Lung sounds are clear, and bowel sounds are present. The patient denies shortness of breath or chest pain but reports occasional dizziness associated with Neurontin (gabapentin) use. A full assessment, medication review, and admission interview were completed. Functionally, the patient is independent with upper and lower body dressing, stands and transfers without assistance, and ambulates indoors without an assistive device. He uses a rollator for community mobility and requires assistance with grocery shopping and light homemaking tasks. Though manual muscle testing (MMT) and range of motion (ROM) are within normal limits in both upper extremities, decreased endurance and increased shortness of breath are noted with moderate exertion. Left upper extremity coordination is impaired due to a longstanding injury, which also causes persistent left-sided pain. Timed Up and Go (TUG) was completed in 9 seconds, indicating the patient is not currently at high risk for falls. A home exercise program (HEP) was reviewed, and the patient demonstrated understanding. Skilled therapy services are recommended to address strength, coordination, and endurance deficits to promote a safe return to prior level of function (PLOF). Date of Order 07/01/2025 Orders Physician Face-to-Face Date: 06/24/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Alcohol abuse with withdrawal delirium 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: Wallace, Brian

SN Careplans

SN WK1: 1 (07/01/25-07/05/25) ,WK2: 1 (07/06/25-07/12/25) ,WK3: 1 (07/13/25-07/19/25) ,WK4: 1 (07/20/25-07/26/25)

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: 4. Assistance needed, but no non-agency caregiver(s) available

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, 8. Currently reports exhaustion

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if

SN Goals

PATIENT-STATED GOAL: "I want to get back to my art."

GOALS
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
* 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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 07/01/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Brian Wallace
2340 Willow Vale Dr
Fallston, MD 21047
PHONE: 8553624687 FAX: 18555801397 NPI: 1801864350

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 : 06/24/2025

27. Attending Physician's Signature and Date Signed **08/08/2025**: 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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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 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, 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

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0160 - Depression, D0700 - Social Isolation, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M2020 - Oral Med Management, swelling in legs/around eyes, M1400 - Dyspnea, M1033 - Exhaustion, increased urine output, foul-smelling urine, swelling of affected area, limited range of motion, pain radiating to arms/legs, balance deficit, Pain Interference with ADLs, Pain Effect on Sleep, swell/redness surround. skin, red/tender pressure points

PROCEDURES: cough/deep breathing exercises, coordinate/arrange preparation of missing meals, coordinate/arrange long-term socialization activities

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, 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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule, patient 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

* 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

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

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/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

PT Careplans

PT WK1: 1 (07/01/25-07/05/25) ,WK2: 1 (07/06/25-07/12/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170F1 - Toilet 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, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer

PROCEDURES: Therapeutic exercises, dynamic standing balance exercises, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06.

PT Goals

PATIENT-STATED GOAL: To improve coordination and stability with walking

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Car Transfer - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

Signature of Physician:

Date

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

Date
07/01/2025

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Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 _ Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

1 _ Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Sit to Stand - 06. Independent

Walk 10 Feet - 06. Independent

OT Careplans

OT WK1: 1 (07/01/25-07/05/25) ,WK2: 1 (07/06/25-07/12/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0130A1 - Eating, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear

PROCEDURES: home exercise program: For endurance training with 5lb weight and 3 set of 10. HEP handout was provided. , equipment training, work simplification/energy conservation, assist with fall prevention, assist with light housekeeping

TEACH PATIENT/CAREGIVER: Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 06. Independent, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Increase endurance to F+, safety during ADLs and IADLs, Balance ex's

OT Goals

PATIENT-STATED GOAL: Leave independently and safe

GOALS
Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Shower/Bathe Self - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Increase endurance to F+

safety during ADLs and IADLs

Balance ex's

Signature of Physician:

Date

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

Date
07/01/2025