Home Health Certification and Plan of Care

Order ID: 1150/11864

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
421282542	08/31/2025	From: 08/29/2025 To: 10/27/2025	16908	217058

6. Patient's Name and Address

Joseph Schield
1441 Sussex Road,
ESSEX, MD 21221
410-686-9041

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 09/23/1940 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	08/31/25

13. ICD	Other Pertinent Diagnoses	Date
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	08/31/25
N18.32	Chronic kidney disease stage 3b	08/31/25
D63.1	Anemia in chronic kidney disease	08/31/25
I70.0	Atherosclerosis of aorta	08/31/25
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	08/31/25
J90.	Pleural effusion not elsewhere classified	08/31/25
M51.26	Other intervertebral disc displacement lumbar region	08/31/25
N20.0	Calculus of kidney	08/31/25
I45.10	Unspecified right bundle-branch block	08/31/25
K76.0	Fatty (change of) liver not elsewhere classified	08/31/25
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	08/31/25
M54.40	Lumbago with sciatica unspecified side	08/31/25
G89.29	Other chronic pain	08/31/25
F41.9	Anxiety disorder unspecified	08/31/25
K21.9	Gastro-esophageal reflux disease without esophagitis	08/31/25
E78.5	Hyperlipidemia unspecified	08/31/25
Z79.82	Long term (current) use of aspirin	08/31/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	08/31/25
Z87.891	Personal history of nicotine dependence	08/31/25

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

Buspar - Buspirone Hydrochloride 15 mg 1 Tablet by mouth twice a day For anxiety
iron-vitamin C (VITRON-C) 65-125 MG TABS 65-125 MG , take 1 tablet by mouth once a day Supplement
Lipitor - Atorvastatin Calcium eq 40 mg base 1 Tablet by mouth at bedtime For high cholesterol
Norvasc - Amlodipine Besylate eq 10 mg base 1 Tablet by mouth once a day For high blood pressure and my heart
Aspirin 81Mg - Aspirin 81 mg , take 1 tablet by mouth once a day For my heart
Jardiance - Empagliflozin 12.5 mg, take 1 Tablet by mouth once a day For my blood sugars
Vitamin D - Ergocalciferol 1,000 Units , Take 1 capsule by mouth once a day Supplement
Cardura - Doxazosin Mesylate eq 4 mg base 1 Tablet by mouth once a day For my blood pressure
Cozaar - Losartan Potassium 100 mg 1 Tablet by mouth once a day For my blood pressure and heart.
Proscar - Finasteride 5 mg 1 Tablet by mouth once a day For my prostate
Humulin R - Insulin Recombinant Human 100 units/ml 15 units subcutaneous twice a day In morning and bedtime for blood sugars

14. DME and Supplies:

diabetic supplies, bath bench, cane, walker, grab bars

15. Safety Measures:

ambulates with device, standard precautions, fall precautions, diabetic precautions, bleeding precautions

16. Nutrition:

low sodium, diabetic

17. Allergies:

ace inhibotors zoloft

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Ambulation, Endurance

18.B. Activities Permitted

Walker, Cane, 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: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

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

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive Chronic Kidney Disease With Stage 1 Through Stage 4 Chronic Kidney Disease, Or Unspecified Chronic Kidney 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.

Clinical Condition Requiring Homecare:

The patient is an 84-year-old male who was recently discharged from the hospital following an admission for shortness of breath, palpitations, and respiratory failure. He lives alone in a single-family home but receives intermittent assistance from family members. The patient is alert and oriented, verbalizes understanding of his medication regimen, and has all medications present in the home; however, reinforcement of teaching is recommended. His past medical history includes anemia, benign prostatic hyperplasia, chronic kidney disease stage III, diabetes mellitus (managed with continuous glucose monitoring and insulin pen), fatty liver, gastroesophageal reflux disease, hypertension, hyperlipidemia, and carpal tunnel syndrome. A head-to-toe assessment revealed no wounds or skin abnormalities. The patient reports no pain but endorses weakness and unsteadiness on his feet, contributing to a high fall risk. His Timed Up and Go (TUG) score was 17.52 seconds without an assistive device, confirming impaired gait coordination. He was able to complete straight leg raises, lower extremity abduction/adduction, long arc quads, and seated marching (10 repetitions each), and ambulated continuously for 1 minute and 25 seconds before fatigue and gait instability limited activity. He currently uses a narrow-based cane for mobility and demonstrates independence with bathing, dressing, toileting, shower transfers, and sit-to-stand transfers, all with safe techniques. Upper extremity strength is 5/5 bilaterally. The patient was instructed on pacing and breathing techniques to manage exertional shortness of breath. Physical therapy and occupational therapy were recommended to address weakness, poor endurance, and fall risk, though the patient does not require ongoing occupational therapy at this time. Family members were present during the session and committed to assisting with prescribed home exercises.
 Date of Order 08/31/2025 Orders Physician Face-to-Face Date: 08/24/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Hypertensive Chronic Kidney Disease With Stage 1 Through Stage 4 Chronic Kidney Disease, Or Unspecified Chronic Kidney Disease Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 <span style="white-space: pre; white-space:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 08/31/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Rosina Shrestha
4920 Campbell Blvd
Baltimore, MD 21236
PHONE: FAX: NPI: 1760895346

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 : 08/24/2025

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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normal;"> 1 - SOC - SN Notes: PT Eval Notes: OT Eval Notes: Physician Shrestha, Rosina

SN Careplans

SN WK2: 1 (08/31/25-09/06/25) ,WK3: 1 (09/07/25-09/13/25) ,WK4: 1 (09/14/25-09/20/25)

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, blood sugar < 60 > 300

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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, meal preparation, M2020 - Oral Med Management, M1033 - Exhaustion, lightheadedness, weak pulses in feet, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, heartburn/indigestion, limited range of motion, limited endurance, limited strength, muscle weakness, balance deficit, B1000 - Vision Deficit, discolored patches of skin, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, monitor intake & output, home exercise program, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, 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, * lifestyle modification to manage blood condition including dietary changes bleeding precautions, 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, * 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, * low-fat diet lifestyle modifications to manage esophageal condition, related medication(s) purpose, schedule, * how to promote optimized mobility with strength balance dexterity range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing prevent constipation, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, 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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: "I want to be able to walk to my mailbox and down in the basement".

GOALS
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 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 modification to manage blood condition including dietary changes
* bleeding precautions
* recalls related medication(s) purpose, schedule

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
* 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 promote optimized mobility with strength
* balance
* dexterity
* range-of-motion therapeutic exercises
* promotion of peripheral circulation
* fluid and diet intake to promote healing
* prevent constipation
* 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
* low-fat diet
* lifestyle modifications to manage esophageal condition
* 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/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	08/31/2025

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meal preparation is available to patient for all meals

PT Careplans

PT WK2: 1 (08/31/25-09/06/25) ,WK3: 2 (09/07/25-09/13/25) ,WK4: 2 (09/14/25-09/20/25) ,WK5: 2 (09/21/25-09/27/25) ,WK6: 1 (09/28/25-10/04/25) ,WK7: 1 (10/05/25-10/11/25) ,WK8: 1 (10/12/25-10/18/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: Medication was reviewed with the caregivers and the patient , Home exercises : SLR, LE ABD/ADD, LONG ARC , MARCHING , AND HEEL /TOE RAISES --10X1 REPS , cough/deep breathing exercises, incentive spirometer, 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 - 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, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: To get stronger and walk longer distance

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

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 - 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

OT Careplans

OT WK1: 6 (08/29/25-08/30/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

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, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: Eval only

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

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

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Signature of Physician:

Date

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

Date
08/31/2025