Home Health Certification and Plan of Care

Order ID: 1150/12227

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
32720918	09/08/2025	From: 09/08/2025 To: 11/05/2025	17102	217058

6. Patient's Name and Address

Doyle Lewis
1102 Fallwood Court,
Dundalk, MD 21222-
443-956-3493

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 02/22/1944 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I95.1	Orthostatic hypotension	09/08/25

13. ICD	Other Pertinent Diagnoses	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	09/08/25
N18.31	Chronic kidney disease stage 3a	09/08/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	09/08/25
J98.6	Disorders of diaphragm	09/08/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	09/08/25
H47.012	Ischemic optic neuropathy left eye	09/08/25
M48.02	Spinal stenosis cervical region	09/08/25
E78.5	Hyperlipidemia unspecified	09/08/25
D53.9	Nutritional anemia unspecified	09/08/25
I21.4	Non-ST elevation (NSTEMI) myocardial infarction	09/08/25
K52.9	Noninfective gastroenteritis and colitis unspecified	09/08/25
E53.8	Deficiency of other specified B group vitamins	09/08/25
F32.A	Depression unspecified	09/08/25
K21.9	Gastro-esophageal reflux disease without esophagitis	09/08/25
E66.9	Obesity unspecified	09/08/25
Z79.82	Long term (current) use of aspirin	09/08/25
Z85.46	Personal history of malignant neoplasm of prostate	09/08/25
Z91.81	History of falling	09/08/25

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

ipratropium-albuterol (DUO-NEB) 3mL nebulizer solution inhalant every 4-6 hours As needed for SOB and wheezing
Tylenol - Acetaminophen 1000mg tablet by mouth every 8 hours severe pain (7-10), moderate pain (4-6) may also be administered per patient
Cyanocobalamin - Cyanocobalamin 1 mg/ml Inject 1 vial intramuscular once a week Supplement
Mucinex - Guaifenesin 600 mg take 1 tablet by mouth every 12 hours Cough
Aspirin 81Mg - Aspirin 81 mg, Take 1 tablet by mouth once a day Blood thinner
Atorvastatin - Atorvastatin Calcium 80 mg, Take 1 tablet by mouth at bedtime HLD
Wellbutrin - Bupropion Hydrochloride 300mg, take 1 tablet by mouth once a day Depression
Cetirizine Hydrochloride - Cetirizine Hydrochloride 10 mg Take 1 tablet by mouth at bedtime
Lexapro - Escitalopram Oxalate eq 10 mg base Take 1 tablet by mouth once a day Depression
Advair - Fluticasone Propionate: Salmeterol Xinafoate 100-62.5-25mcg inhalant once a day SOB and wheezing
Methocarbamol - Methocarbamol 500 mg Take 1 tablet by mouth twice a day As needed for muscle spasm
Singulair - Montelukast Sodium eq 10 mg base Take 1 tablet by mouth at bedtime
Nitroglycerin - Nitroglycerin 0.4 mg/hr Take 1 tablet sublingual as necessary Every 5 mins as needed for chest pain
Omeprazole - Omeprazole 20 mg Take 1 capsule by mouth once a day Nausea/vomiting
Ondansetron - Ondansetron 4 mg Take 1 tablet by mouth twice a day As needed for nausea/vomiting

14. DME and Supplies:

walker, grab bars, bath bench

15. Safety Measures:

bleeding precautions, medication safety, walker precautions, standard precautions, fall precautions, bathroom safety, anticoagulant precautions, ambulates with device

16. Nutrition:

regular

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Walker, Up As Tolerated

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: 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
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Orthostatic Hypotension, 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 81-year-old male with a past medical history significant for coronary artery disease (CAD), obstructive sleep apnea (OSA), hypertension, and hyperlipidemia. He was recently hospitalized due to generalized weakness, dyspnea, and hypotension and is now admitted to home health services for continued management and rehabilitation. At the time of assessment, the patient was alert and oriented x4, reporting neck pain at a level of 5/10, effectively managed with Tylenol. He denied acute chest pain but endorsed occasional fatigue, dizziness, and cough. On exam, skin was warm, dry, and intact; bowel sounds were active; and wheezing was noted with exertion. Vital signs were within normal limits, and mild bilateral lower extremity edema was observed. The patient resides with his wife and family members in a trailer home and ambulates with a rolling walker or narrow-based cane. He requires supervision for bathing and dressing, reports difficulty stepping into the shower, and uses grab rails for toileting, where he requires standby assistance. Sit-to-stand transfers require contact guard assistance. Strength testing revealed bilateral upper extremity weakness at 4-/5 MMT. During therapy, he tolerated straight leg raises, lower extremity abduction/adduction, long arc quadriceps exercises, marching in place, and heel raises (10 reps each). He fatigued easily, tolerating only 2 minutes of continuous ambulation before requiring rest. He was instructed to focus on controlled breathing during activities to help manage exertional dyspnea. Education was provided on medication compliance, side effects, foot elevation while sitting, correct use of the nebulizer, and fall prevention strategies. Both the patient and caregiver verbalized understanding. The plan of care includes skilled nursing for cardiopulmonary monitoring and medication management, along with physical therapy to address strength deficits, endurance, and safety in transfers and ambulation. Continued family involvement in care was encouraged, and follow-up <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-visits">visits</mh> will focus on progressive strengthening, activity tolerance, and safety reinforcement. <span style="white-space: pre; font-size: 14px; white-space:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 09/08/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Chukwuma Ebo
1124 Mace Ave
Essex, MD 21221
PHONE: 4103916996 FAX: 14106876877 NPI: 1275548729

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 : 08/29/2025

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;">
 Date of Order 09/08/2025 Orders Physician Face-to-Face Date: 08/29/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat due to Orthostatic Hypotension 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 Ebo, Chukwuma

SN Careplans

SN WK1: 1 (09/08/2025 - 09/13/2025), WK3: 1 (09/21/2025 - 09/27/2025), WK4: 1 (09/28/2025 - 10/02/2025)

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, 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

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, wheezing, abn cholesterol > 200 mg/dL, muscle weakness, Pain Interference with ADLs, daytime fatigue, balance deficit

PROCEDURES: Medication Review: Medication review completed by the patient/caregiver., cough/deep breathing exercises, incentive spirometer

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, * low cholesterol dietary guidelines, 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 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule

SN Goals

PATIENT-STATED GOAL: To get better generally

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 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
* low cholesterol dietary guidelines
* 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/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
* 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

PT Careplans

PT WK1: 7 (09/08/25-09/13/25)

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: The medication was reviewed with the patient , Home exercises: Slr, le abd/add, long arc , marching and heel raises 10x2 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, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or

PT Goals

PATIENT-STATED GOAL: To get stronger and walk with out dyspnea

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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles SN RN

Date

09/08/2025

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clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

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: 1 (09/08/25-09/13/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, 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

PROCEDURES: ADLS , Medication reviewed with patient/caregiver : Medication Review , cough/deep breathing exercises, transfers training, therapeutic exercises

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, 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, 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: Patient wants to get better and stronger

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

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

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

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
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/08/2025