Home Health Certification and Plan of Care

Order ID: 1150/12829

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
88109796	10/01/2025	From: 10/01/2025 To: 11/29/2025	17984	217058

6. Patient's Name and Address
Donald Sewell
310 Locust Drive,
CATONSVILLE, MD 21228-
443-560-7030

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 02/05/1983 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
J45.51	Severe persistent asthma with (acute) exacerbation	10/01/25

13. ICD	Other Pertinent Diagnoses	Date
J96.01	Acute respiratory failure with hypoxia	10/01/25
J96.02	Acute respiratory failure with hypercapnia	10/01/25
J69.0	Pneumonitis due to inhalation of food and vomit	10/01/25
J30.2	Other seasonal allergic rhinitis	10/01/25
M62.81	Muscle weakness (generalized)	10/01/25

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
Proventil-Hfa - Albuterol Sulfate Take 90 mg, inhalant every 6 hours Take 90 mg Q6H
Singulair - Montelukast Sodium eq 10 mg base 10 mg tablet by mouth at bedtime For allergies
Breo Ellipta - Fluticasone Furoate: Vilanterol Trifenatate 1 puff inhalant once a day Steroid

14. DME and Supplies:
rolling walker

15. Safety Measures:
activity supervision, ,

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
hay mold

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Exercises Prescribed, Transfer bed/Chair, 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: No

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

Homebound status: Due to diagnosis of Severe Persistent Asthma With Exacerbation, 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 42-year-old male with a past medical history significant for asthma and seasonal allergies who was recently hospitalized for pneumonia. During hospitalization, he required several days of ventilator support in the intensive care unit and remained admitted for a total of seven days. This acute illness and period of immobility contributed to significant deconditioning, muscle mass loss, poor balance, and limited mobility at the time of discharge. Since returning home, the patient has demonstrated marked improvement in functional mobility. He now ambulates independently within the home without the use of a rolling walker, although with a reduced gait cadence, and is able to negotiate stairs independently. However, he continues to require assistance with upper and lower body dressing, showering, meal preparation, and outdoor ambulation. Examination revealed decreased strength and limited active range of motion (AROM) in the left upper extremity, contributing to functional limitations, as well as overall poor endurance. Although his Timed Up and Go (TUG) test was completed in nine seconds-indicating no immediate fall risk-he exhibits mild unsteadiness during dynamic standing and ambulation. The patient receives caregiver support in the afternoons and evenings. He reports persistent left biceps pain, which interferes with sleep. The clinician recommended alternating ice and heat applications, use of electrical stimulation (E-stim), and soft tissue massage for pain management. A home exercise program (HEP) was provided, including seated and standing lower extremity therapeutic exercises and active-assisted range of motion (AAROM) activities for the left upper extremity to improve strength, flexibility, and endurance. The patient was advised to follow up with his primary care provider today and to request a referral for outpatient physical therapy for continued rehabilitation. Ongoing skilled therapy services are indicated to enhance strength, endurance, functional independence, and safety with mobility and daily activities.
 Date of Order 10/01/2025 Orders Physician Face-to-Face Date: 09/29/2025 Clinical Condition Requiring Home Care per Certifying Physician: PT eval and treat, OT eval and treat due to Severe Persistent Asthma With Exacerbation 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 - PT Notes: soc Physician Wagle, Laxman

SN Careplans

SN Goals

PT Careplans

PT WK1: 1 (10/01/25-10/04/25) ,WK2: 1 (10/05/25-10/11/25) ,WK3: 1 (10/12/25-10/18/25) ,WK4: 1 (10/19/25-10/25/25)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 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;

PT Goals

PATIENT-STATED GOAL: To walk independently

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 10/01/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Laxman Wagle
900 S Caton Ave
Baltimore, MD 21229
PHONE: 667-234-3120 FAX: 16672343525 NPI: 1588275614

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 : 09/29/2025

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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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: GG0130E1 - Shower/Bathe Self, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, 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, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, M1033 - Unintentional Weight Loss, limited strength, limited endurance, muscle weakness, Pain Effect on Sleep

PROCEDURES: Therapeutic exercise , Dynamic standing balance , Medication Review-Medications reviewed with patient/caregiver., gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * 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, 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, 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. 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

* recalls related medication(s) purpose, schedule

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. 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

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	10/01/2025