Home Health Certification and Plan of Care

Order ID: 1150/13112

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6GD7UQ5QD63	10/08/2025	From: 10/08/2025 To: 12/05/2025	18118	217058

6. Patient's Name and Address
Joseph Dunne
4 Avery Ct,
ROSEDALE, MD 21237-
410-687-5763

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 03/06/1941 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
L03.116	Cellulitis of left lower limb	10/08/25

13. ICD	Other Pertinent Diagnoses	Date
L97.429	Non-prs chronic ulcer of left heel and midfoot w unsp severt	10/08/25
L89.310	Pressure ulcer of right buttock unstageable	10/08/25
I10.	Essential (primary) hypertension	10/08/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	10/08/25
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	10/08/25
I87.8	Other specified disorders of veins	10/08/25
I48.91	Unspecified atrial fibrillation	10/08/25
L30.2	Cutaneous autosensitization	10/08/25
Z95.0	Presence of cardiac pacemaker	10/08/25

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

Eucerin External Lotion (Emollient Apply to BLE topically topical once a day every day shift for Dryness
Acetaminophen - Acetaminophen Oral Tablet 500 MG ,Give 1000 mg by mouth every 8 hours as needed for pain moderate (4 to 6) hrs
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 MG Oral Capsule by mouth at bedtime At night for BPH
hydroCHLOROthiazide 25 MG Oral Tablet by mouth once a day Give 25 mg by mouth one time a day for HTN hold for SBP less THAN 100 and HR less than 50
Lisinopril - Lisinopril 40 mg 40 MG Oral Tablet by mouth once a day for HTN hold for SBP less than 100 and HR less than 50
Loratadine - Loratadine 10 mg 10 MG Oral Tablet Give 5 mg by mouth once a day for allergy. Pt is allergic to fish and egg

14. DME and Supplies:
grab bars, sock aid, , , cane, 4 wheeled walker

15. Safety Measures:
walker precautions, , ambulates with device, , smoke detectors , remove environmental barriers, bedrails up while in bed, ambulates with assistance, , activity supervision, bathroom safety, hand rails,

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
fish hydralazine seafood egg

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Wheelchair, Exercises Prescribed, Walker, Cane, Partial Weight Bearing, 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: 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
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Cellulitis Of Left Lower Limb, 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 resides with his wife, his primary caregiver, in a single-family home. He was recently hospitalized following multiple falls associated with an episode of acute confusion and delirium, which has since fully resolved. Upon discharge, he relocated to the basement level of his home, where he now spends most of his time; however, the space is cluttered and restricts his ability to ambulate safely with a rolling walker. The spouse was instructed to declutter and reorganize the area to improve accessibility and safety during mobility. The patient reports feeling "back to normal" with no ongoing confusion and denies pain, though he occasionally experiences mild leg discomfort relieved by acetaminophen. His wife confirms administration of two 500 mg tablets of Tylenol prior to the nurse's visit. On assessment, the patient was alert and oriented 3, demonstrating stable vital signs and clear bilateral lung sounds. He ambulates short household distances with a rolling walker and is able to ascend four low steps with effort. He keeps a urinal within reach for convenience but remains capable of walking to the nearby bathroom when needed. Examination revealed a nearly healed left heel ulcer with full epithelialization, no drainage, erythema, or signs of infection. Wound care was completed according to current physician orders, and the wound site was documented and photographed for ongoing monitoring. The patient's wife demonstrates good understanding of wound management but required reinforcement on proper medication administration parameters, particularly regarding the patient's antihypertensive regimen. The patient is currently recovering from cellulitis, a buttock ulcer, and a left heel ulcer, all showing significant improvement. He presents with mild mobility limitations and requires supervision and assistance for safe transfers and ambulation. Education was provided to the patient and spouse regarding consistent use of the walker during mobility, energy conservation, and fall prevention strategies. The importance of holding antihypertensive medications if systolic blood pressure falls below 100 mmHg or heart rate below 50 bpm was emphasized, and the spouse verbalized understanding. The patient was encouraged to participate actively in upcoming physical and occupational therapy sessions to improve strength, endurance, and overall functional mobility. Continued wound care per physician orders with dressing changes three times per week or as needed will be maintained, with weekly RN reassessment to ensure full healing and ongoing caregiver education. Emergency contact information and follow-up instructions were provided to the patient and spouse, who verbalized understanding and agreement with the current care plan.
 Date of Order 10/08/2025 Orders Physician Face-to-Face Date: 09/30/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Cellulitis Of Left Lower Limb 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: soc PT Eval Notes: OT Eval Notes: Physician Seo, Kyung

SN Careplans	SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 10/08/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Kyung Seo
9105 Franklin Square Dr Ste 214
Baltmore, MD 21237
PHONE: 4437777631 FAX: NPI: 1467868257

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 : 09/30/2025

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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SN WK1: 2 (10/08/25-10/11/25) ,WK2: 2 (10/12/25-10/18/25) ,WK3: 1 (10/19/25-10/25/25) ,WK4: 1 (10/26/25-11/01/25) ,WK5: 1 (11/02/25-11/08/25) ,WK6: 1 (11/09/25-11/15/25)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 5. Decline in mental, emotional, or behavioral status 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
Advance Directive:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, meal preparation, M1400 - Dyspnea, muscle weakness, limited range of motion, poor muscle tone, limited strength, limited endurance, Pain Interference with Therapy activities, B1000 - Vision Deficit, balance deficit, Pain Interference with ADLs, Pain Effect on Sleep, bruising/discoloration, discolored patches of skin, #1 - Open Wound - Posterior Left Heel - Left heel: Clean with saline, apply collagen, calcium alginate, cover with a bordered foam. Change every Monday, Wednesday and Friday.

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: Left heel: Clean with saline, apply collagen, calcium alginate, cover with a bordered foam. Change every Monday, Wednesday and Friday., teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, 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, * 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * how to manage skin condition including physician-prescribed treatment skin care bathing sun protection diet exercise, 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, 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-STATED GOAL: To get stronger and ambulate with minimal assistance

GOALS
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
* how to manage skin condition including physician-prescribed treatment
* skin care
* bathing
* sun protection
* diet
* exercise
* 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
* 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

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
* 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

PT Careplans

PT WK1: 1 (10/08/25-10/11/25) ,WK2: 2 (10/12/25-10/18/25) ,WK3: 2 (10/19/25-10/25/25) ,WK4: 1 (10/26/25-11/01/25) ,WK5: 1 (11/02/25-11/08/25) ,WK6: 1 (11/09/25-11/15/25)

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 --10x2, Home exercises: Slr, le abd/add, long arc --10x2, cough/deep breathing 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.

PT Goals

PATIENT-STATED GOAL: To walk better and get back upstairs in his room

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 150 Feet - 04. Supervision or touching assistance

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

Signature of Physician:

Date

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

Date
10/08/2025

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Supervision or touching, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance

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

12 Steps - 04. Supervision or touching assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	10/08/2025