Home Health Certification and Plan of Care

Order ID: 1150/13165

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1VN6EY8HT53	10/13/2025	From: 10/13/2025 To: 12/10/2025	18341	217058

6. Patient's Name and Address

Robert Owens
111 Centre Apt 402,
BALTIMORE, MD 21201-
443-466-7018

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 03/24/1939 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I11.0	Hypertensive heart disease with heart failure	10/13/25

13. ICD	Other Pertinent Diagnoses	Date
I50.23	Acute on chronic systolic (congestive) heart failure	10/13/25
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	10/13/25
L89.152	Pressure ulcer of sacral region stage 2	10/13/25
I65.23	Occlusion and stenosis of bilateral carotid arteries	10/13/25
I42.9	Cardiomyopathy unspecified	10/13/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	10/13/25
J90.	Pleural effusion not elsewhere classified	10/13/25
I82.621	Acute embolism and thrombosis of deep veins of r up extrem	10/13/25
I87.2	Venous insufficiency (chronic) (peripheral)	10/13/25
N30.40	Irradiation cystitis without hematuria	10/13/25
E78.49	Other hyperlipidemia	10/13/25
K57.20	Dvtrcli of lg int w perforation and abscess w/o bleeding	10/13/25
N52.37	Erectile dysfunction following prostate ablative therapy	10/13/25
D69.6	Thrombocytopenia unspecified	10/13/25
K21.9	Gastro-esophageal reflux disease without esophagitis	10/13/25
R29.6	Repeated falls	10/13/25
R33.9	Retention of urine unspecified	10/13/25
R13.12	Dysphagia oropharyngeal phase	10/13/25
R41.841	Cognitive communication deficit	10/13/25
Z79.82	Long term (current) use of aspirin	10/13/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	10/13/25
Z79.02	Long term (current) use of antithrombotics/antiplatelets	10/13/25
Z79.01	Long term (current) use of anticoagulants	10/13/25
Z96.1	Presence of intraocular lens	10/13/25

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

Aspirin - Aspirin Low Dose 81 MG Tablet, take Low Dose 81 MG Tablet by mouth once a day for CVA Prophylaxis
Atorvastatin Calcium - Atorvastatin Calcium 40 MG.Oral Tablet ,take 1 tablet by mouth in the evening for Hyperlipidemia
Rollator - - as necessary for ambulation safety

14. DME and Supplies:

4 wheeled walker, diabetic supplies

15. Safety Measures:

cardiac precautions, , , walker precautions, supervision at all times, , bathroom safety, , ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

cardiac diet, low cholesterol, low sodium

17. Allergies:

penicillin

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Up As Tolerated, rollator

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: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive Heart Disease With Heart Failure, 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 86-year-old male with a significant past medical history of congestive heart failure (CHF), hypertension (HTN), gastroesophageal reflux disease (GERD), hyperlipidemia (HLD), type 2 diabetes mellitus (DM2), venous insufficiency, ambulatory difficulties, history of falls, urinary tract infections (UTIs), diverticulosis without bleeding, peripheral edema (P), and erectile dysfunction (ED). The patient resides alone in an apartment within a senior living facility and is alert and oriented 3-4. He reports generalized body pain but is currently not taking any analgesic medication. The patient ambulates with the assistance of a rollator for safety and demonstrates the need for an assistive device due to decreased balance and endurance, making it a taxing effort for him to leave the home. The patient's daughter, Twyla, was present during the visit and assisted with providing information. The patient expressed a strong desire to remain as independent as possible with his care. He is scheduled for a primary care appointment today to receive instruction on a newly prescribed insulin therapy. The prescription was recently received from a skilled nursing facility (SNF). The nurse ensured that all relevant paperwork and medication lists were organized in a folder for the patient to bring to the appointment and instructed him to have the provider reconcile all current prescriptions during the visit. Medication review revealed two active anticoagulation prescriptions, which require clarification. The patient denied any recent falls since discharge. Fall prevention strategies were reviewed in

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 10/13/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Donald Diefendorf
2700 Quarry Lake Dr Ste 300
Baltimore, MD 21209
PHONE: 410-986-4400 FAX: 14109864411 NPI: 1437187002

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 : 10/06/2025

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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detail, and education was provided regarding the use of a medical alert system to enhance safety, especially as the patient lives alone. Tooth decay was observed and should be evaluated by a dental provider. The patient confirmed that transportation for the upcoming appointment is arranged. The plan includes skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> twice weekly for one week, then once weekly for five weeks (SN 2W1, 1W5) to monitor medication compliance, safety, and disease management. Physical therapy (PT), occupational therapy (OT), and home health aide (HHA) services have also been ordered to address mobility, self-care, and functional independence.
 Date of Order 10/13/2025 Orders Physician Face-to-Face Date: 10/06/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adls due to Hypertensive Heart Disease With Heart Failure 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 Physician Diefendorf, Donald

SN Careplans

SN WK1: 1 (10/13/25-10/18/25)

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: 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: D0700 - Social Isolation, Home Safety, Home Safety, M2102c - Med Admin, meal preparation, M2020 - Oral Med Management, M1033 - Exhaustion, abn cholesterol > 200 mg/dL, abnormal blood pressure, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, heartburn/indigestion, muscle weakness, limited strength, limited endurance, difficulty sleeping, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, tooth pain/decay/sensitivity

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, apply anti-embolitic stockings, swallowing exercises, glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals, coordinate/arrange repair of inadequate lighting, coordinate/arrange for maintenance of clean/uncluttered living area, coordinate/arrange long-term socialization activities

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * how to take the patient's blood pressure record the reading, 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 modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, related medication(s) purpose, schedule, * strict compliance with physician orders for anticoagulant administration avoiding activities that create unnecessary risk for injury monitoring for prolonged bleeding from cuts, blood in urine or stool, or unusual bruising for warfarin, limiting foods high in Vitamin K, such as leafy green vegetables, * lifestyle modification to manage blood condition including dietary changes bleeding precautions, 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, * how to optimize mental status with cognition therapy home safety optimize mobility with active and passive range of motion therapeutic exercises diet and fluids to optimize peripheral circulation, related medication(s) purpose, schedule, * how to manage complications of immobility including skin care strength, balance dexterity and range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing and prevent constipation, * 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, * 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 living environment has adequate lighting, patient's living environment is clean/uncluttered, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately

SN Goals

PATIENT-STATED GOAL: to be independent and not return to hospital

GOALS
patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* 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
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to optimize mental status with cognition therapy
* home safety
* optimize mobility with active and passive range of motion therapeutic exercises
* diet and fluids to optimize peripheral circulation
* 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
* lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* low cholesterol dietary guidelines
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* 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
* how to manage complications of immobility including
* skin care
* strength, balance
* dexterity and range-of-motion therapeutic exercises
* promotion of peripheral circulation
* fluid and diet intake to promote healing and prevent constipation

patient/caregiver recalls
* strict compliance with physician orders for anticoagulant administration

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	10/13/2025

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* avoiding activities that create unnecessary risk for injury
* monitoring for prolonged bleeding from cuts, blood in urine or stool, or unusual bruising
* for warfarin, limiting foods high in Vitamin K, such as leafy green vegetables

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

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient living environment has adequate lighting

patient's living environment is clean/uncluttered

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 3 of 3
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