Home Health Certification and Plan of Care

Order ID: 1150/13253

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01194436	08/24/2025	From: 10/23/2025 To: 12/21/2025	15736	217058

6. Patient's Name and Address
Paul Maki
2225 E Baltimore St,
BALTIMORE, MD 21231-
443-278-5491

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 09/21/1948 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.81	Encounter for orthopedic aftercare following surgical amp	08/24/25

13. ICD	Other Pertinent Diagnoses	Date
I87.2	Venous insufficiency (chronic) (peripheral)	08/24/25
L97.811	Non-prs chr ulcer oth prt r low leg limited to brkdwn skin	08/24/25
I11.0	Hypertensive heart disease with heart failure	08/24/25
I50.9	Heart failure unspecified	08/24/25
E78.5	Hyperlipidemia unspecified	08/24/25
N20.0	Calculus of kidney	08/24/25
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	08/24/25
E55.9	Vitamin D deficiency unspecified	08/24/25
K44.9	Diaphragmatic hernia without obstruction or gangrene	08/24/25
E66.9	Obesity unspecified	08/24/25
Z68.32	Body mass index [BMI] 32.0-32.9 adult	08/24/25
Z86.718	Personal history of other venous thrombosis and embolism	08/24/25
Z86.711	Personal history of pulmonary embolism	08/24/25
Z89.432	Acquired absence of left foot	08/24/25
Z86.0101	Personal history of adeno	08/24/25
Z79.01	Long term (current) use of anticoagulants	08/24/25

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

Furosemide - Furosemide 20 MG , Give 1 tablet by mouth once a day
Dabigatran Etexilate - Dabigatran Etexilate 150 MG , Give 1 capsule by mouth twice a day
Atorvastatin Calcium - Atorvastatin Calcium 40 MG , Give 1 tablet by mouth at bedtime
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 MG , Give 1 capsule by mouth in the evening
Acetaminophen - Acetaminophen 500 MG , Give 2 tablet by mouth every 8 hours 8 hours as needed for MILD Pain Pain Scale 1-5
Santyl - Collagenase topical topical once a day and as needed for wound care
Calcium Ag - topical once a day and as needed for wound care

14. DME and Supplies:
walker

15. Safety Measures:
infectious material management, walker precautions, , , bathroom safety, ambulates with device, ambulates with assistance

16. Nutrition:
low sodium, low cholesterol

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
Independent at Home, Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

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 Encounter For Orthopedic Aftercare Following Surgical Amputation, 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 76-year-old male with a complex medical history, including hypertension, recurrent DVT/PE, peripheral vascular disease, osteoarthritis of the right hip, BPH, congestive heart failure, melanoma, and vitamin D deficiency. He was recently discharged from Autumn Lake Rehab following hospitalization for right lower extremity swelling and a left foot transmetatarsal amputation secondary to non-healing ulcers and DVT. He now presents with a 7x3.2 cm wound on the posterior lateral aspect of the right lower leg, exhibiting moderate serosanguineous drainage. Wound care is performed daily using Vashe, Santyl, calcium alginate, gauze, ABD pads, and Kerlix wrap. The patient is unable to perform wound care independently due to limited right hip mobility and plans for a future hip replacement. His son and daughter-in-law are actively involved in care, attending <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-visits">visits</mh> via FaceTime and preparing to assist with wound care. The patient is alert and oriented, ambulates indoors with a rolling walker, and reports no recent falls. He is homebound due to significant exertion required to leave home, supported by a Tinetti score of 12/28. The patient currently resides alone in a row house with five steps at the entrance and uses adaptive devices for daily activities, including a reacher for dressing and a sponge bath setup due to chronic right knee pain. Bed and bathroom are on the first floor. He uses a walker both indoors and outdoors, with supervision required for transfers and curb navigation. He reports limited mobility in his right hip, unable to perform active straight leg raises or abduction. Physical and occupational therapy have been ordered to improve strength and functional mobility with a goal of independently navigating entry steps. His diet includes multigrain bread, fruit, skim milk, and cranberry juice diluted with water. He remains independent with modifications for ADLs and receives support from his son for IADLs such as laundry, errands, and grocery shopping. Follow-up appointments are scheduled with his primary care provider and podiatrist, including monitoring of a recent right-sided hernia and healing from toe amputations. Medication understanding was reviewed, and wound photos have been obtained for documentation.
 Date of Order 10/22/2025 Orders Physician Face-to-Face Date:

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 10/22/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Justin Capasso
815 E Pratt Street
Baltimore, MD 21202
PHONE: 410-637-5700 FAX: 14106375701 NPI: 1457713331

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 : 08/12/2025

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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08/12/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-wound management pt-eval & treat ot-eval & treat dx: Encounter for orthopedic aftercare following surgical amputation Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 4 - Recertification Notes: Recert visit Right lower leg wound, and left foot toe amputations related to ambulatory difficulty and weakness with persistent edema with daily wound care to prevent infection and use of assistive device to prevent accidental falls making it a taxing effort to leave home. Physician Capasso, Justin

SN Careplans

SN WK2: 1 (10/26/25-11/01/25) ,WK3: 1 (11/02/25-11/08/25) ,WK4: 1 (11/09/25-11/15/25) ,WK5: 1 (11/16/25-11/22/25) ,WK6: 1 (11/23/25-11/29/25) ,WK7: 1 (11/30/25-12/06/25)

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: 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: abnormal blood pressure, obesity, open sores/lesions, red/tender pressure points

PROCEDURES: wound care: Cleansed gauze applied Wound care is cleanse with Vashe apply Santyl and calcium alginate DCD cover gauze/ABD pad wrap in kerlix and secure with tape. Moderate serosanguineous drainage noted. Hydrofera blue added, wound care: small right leg interior abrasion wound noted 0.4cm in diameter, red wound bed with minimal bloody drainage. Cleansed gauze applied , Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: To right lower leg wound. Wound care is cleanse with Vashe apply Santyl and calcium alginate DCD cover gauze/ABD pad wrap in kerlix and secure with tape daily., coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange home modifications for hearing impaired, i.e. alarms

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, * 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 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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 hearing-impaired including installing special fire-detector/C O2 alarms, related medication(s) purpose, schedule, 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 performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: to be able to walk the step to entry to home

GOALS
patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* low cholesterol dietary guidelines
* 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 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

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

meal preparation is available to patient for all meals

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

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

patient is adequately supervised

caregiver performs medical/rehabilitation treatments with adequate competence

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	10/22/2025

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