

Home Health Certification and Plan of Care				Order ID: 1150/12666	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
7K60CY0KX43		09/24/2025		From: 09/24/2025 To: 11/21/2025	
				4. Medical Record No.	
				17591	
				5. Provider No.	
				217058	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Henry Hopkins				HomeCentris Healthcare LLC	
7428 Holabird Ave,				10 Crossroads Drive, Suite 102	
DUNDALK, MD 21222-				Owings Mills, MD 21117-8284	
443-807-3984				410-321-8448	
				1487113239	
8. DOB				9. Sex	
08/01/1952				Male	
11. ICD		Principal Diagnosis		Date	
S72.011D		Unsp intracap fx right femur subs for clos fx w routn heal		09/24/25	
13. ICD		Other Pertinent Diagnoses		Date	
I12.0		Hyp chr kidney disease w stage 5 chr kidney disease or ESRD		09/24/25	
E11.22		Type 2 diabetes mellitus w diabetic chronic kidney disease		09/24/25	
N18.6		End stage renal disease		09/24/25	
D63.1		Anemia in chronic kidney disease		09/24/25	
E83.9		Disorder of mineral metabolism unspecified		09/24/25	
F03.911		Unspecified dementia unspecified severity with agitation		09/24/25	
I25.10		AthscI heart disease of native coronary artery w/o ang pctrs		09/24/25	
I35.0		Nonrheumatic aortic (valve) stenosis		09/24/25	
E78.5		Hyperlipidemia unspecified		09/24/25	
F32.A		Depression unspecified		09/24/25	
I25.2		Old myocardial infarction		09/24/25	
G51.0		Bell's palsy		09/24/25	
Z99.2		Dependence on renal dialysis		09/24/25	
Z94.4		Liver transplant status		09/24/25	
Z79.82		Long term (current) use of aspirin		09/24/25	
Z79.891		Long term (current) use of opiate analgesic		09/24/25	
Z91.81		History of falling		09/24/25	
14. DME and Supplies:				15. Safety Measures:	
N/A				activity supervision	
16. Nutrition:				17. Allergies:	
renal diet				no known allergies	
18.A. Functional Limitations				18.B. Activities Permitted	
Bowel/Bladder Incontinence,				Up As Tolerated	
19. Mental & Pyschosocial Status:		COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions!3. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc., HISTORY OF DEPRESSION: Yes			
20. Prognosis:		fair			
22. A Rehabilitation Potential:		22.B.Discharge Plans			
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.		family/caregiver will be responsible for managing treatment family/caregiver will be responsible for managing treatment			
Homebound status:		Due to diagnosis of Unspecified Intracapsular Fracture Of Right Femur, Subsequent Encounter For Closed Fracture With Routine Healing, 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 assitive mobility device.			
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 09/24/2025					
24. Physician's Name and Address		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.			
Kira Alcegueire		F2F date : 09/15/2025			
301 Mason Lord Dr					
Blatimore, MD					
PHONE: 4105503350 FAX: 14105503598 NPI: 1417574872					
27. Attending Physician's Signature and Date Signed		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.			
10/14/2025 Date of physician last face-to-face		PAGE 1 of 3			

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	09/24/2025

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	recognition of activities that bring pleasure * preventive care * recalls related medication(s) purpose, schedule patient/caregiver recalls * management of mental health condition including joining a peer group * maintaining regular contact with mental health professional * avoiding known stressors * controlling impulses * recalls related medication(s) purpose, schedule patient/caregiver recalls * bowel incontinence management including dietary changes * bowel training * skin care * recalls related medication(s) purpose, schedule 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
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PT Careplans PT WK1: 1 (09/24/25-09/27/25) ,WK2: 1 (09/28/25-10/04/25) 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 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: Medication Review: The medication was reviewed with the care giver --spouse, Home exercises: SLR. LE ABD/ADD, LONG ARC --10X3 WITH THE CAREGIVER ASSISTANCE, 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 - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 06. Independent, Car Transfer - 04. Supervision or touching assistance, 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	PT Goals PATIENT-STATED GOAL: The caregiver said that the patient is at base line GOALS Toilet Transfer - 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 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 - 04. Supervision or touching assistance Chair to Bed to Chair - 04. Supervision or touching assistance Car Transfer - 04. Supervision or touching assistance Walk 10 Feet - 06. Independent Walk 50 ft with 2 Turns - 06. Independent Walk 150 Feet - 06. Independent
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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