Home Health Certification and Plan of Care

Order ID: 1150/13633

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1FJ9DA8GM55	11/03/2025	From: 11/03/2025 To: 01/02/2026	18777	217058

6. Patient's Name and Address

Christopher Henry
4213 Thayer Court,
BROOKLYN, MD 21225-
667-219-5443

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 12/09/1982 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I13.2	Hyp hrt & chr kdny dis w hrt fail and w stg 5 chr kdny/ESRD	11/03/25

13. ICD	Other Pertinent Diagnoses	Date
I50.20	Unspecified systolic (congestive) heart failure	11/03/25
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	11/03/25
N18.6	End stage renal disease	11/03/25
D63.1	Anemia in chronic kidney disease	11/03/25
N12.	Tubulo-interstitial nephritis not spcf as acute or chronic	11/03/25
D72.819	Decreased white blood cell count unspecified	11/03/25
E78.5	Hyperlipidemia unspecified	11/03/25
D47.2	Monoclonal gammopathy	11/03/25
H91.90	Unspecified hearing loss unspecified ear	11/03/25
Z99.2	Dependence on renal dialysis	11/03/25
Z86.19	Personal history of other infectious and parasitic diseases	11/03/25

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

Glucagon - Glucagon Hydrochloride 1 mg, IM, 5000 units= 1 mL, Subcut
subcutaneous every 8 hours glucagon, 1 mg, IM, As Indicated, PRN
heparin(heparin (for subcutaneous
injection)), 5000 units= 1 mL, Subcut,
q8h
Ondansetron - Ondansetron 4 mg= 2 mL , Tablet by mouth every 8 hours
Renvela - Sevelamer Carbonate 800 mg by mouth three times a day
Lasix - Furosemide 80 mg by mouth in the morning
Cinacalcet Hydrochloride - Cinacalcet Hydrochloride 30 mg by mouth twice a day
Vit D12 1.25 mg by mouth once a day
Crestor - Rosuvastatin Calcium 20 mg by mouth at bedtime
Heparin - Heparin Sodium 30000 unit subcutaneous twice a day
Dextrose 50% - Dextrose 12.5 gm= 25 mL IV Push IV as necessary For
Peritoneal Dialysis. Dextrose 50% in Water, 12.5 gm= 25 mL,
IV Push, As Indicated, PRN

14. DME and Supplies:

IV supplies, hand held shower

15. Safety Measures:

remove environmental barriers, infectious material management, diabetic precautions, , avoid temperature extremes, bathroom safety,

16. Nutrition:

fluid restriction, low sodium,

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Dyspnea With Minimal Exertion

18.B. Activities Permitted

No Restrictions,

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 1. Rarely, 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 Hypertensive Heart And Chronic Kidney Disease With Heart Failure And With Stage 5 Chronic Kidney Disease, Or End Stage Renal Disease, 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 medical history significant for type 2 diabetes mellitus, hypertension, hyperlipidemia, hearing impairment, and end-stage renal disease (ESRD) currently managed with hemodialysis four times weekly (Monday, Tuesday, Thursday, and Friday). He was recently hospitalized after experiencing severe abdominal pain during a dialysis session, which progressed to shock requiring admission to the intensive care unit. Following stabilization, the patient was discharged home, where he resides with his mother in a multilevel residence with one small step to enter and thirteen stairs leading to the bedroom and bathroom on the second floor. During assessment, the patient was alert and oriented to person, place, and time. He reported shortness of breath on exertion but denied chest pain, palpitations, or dizziness. Lung sounds were clear bilaterally, bowel sounds were normoactive with the last bowel movement noted the previous day, and he reported normal urination. No edema was present in the lower extremities, pedal pulses were palpable, and skin was dry and intact. A left arm arteriovenous fistula was observed, patent and without signs of infection. The patient is ambulatory without the use of an assistive device but demonstrates generalized weakness, decreased lower extremity strength, limited endurance, impaired balance, and unsteady gait, increasing his risk for falls. He is independent in basic activities of daily living (BADLs) but requires supervision to minimal assistance for instrumental ADLs (IADLs). He uses paratransit services for transportation and has adaptive equipment in the home, including grab bars and a bath bench, though he reports not using them regularly. Education was provided on medication management, recognition of infection signs at the fistula site, adherence to dialysis and fluid restrictions, fall prevention, and the importance of using safety equipment as recommended. The patient and his caregiver verbalized understanding of all teaching provided. Skilled physical therapy is recommended to address decreased strength, balance, and functional mobility, with a focus on safe transfer training, stair negotiation, endurance building, and reinforcement of safety awareness. The planned frequency is twice weekly for two weeks, then once weekly for four weeks. The patient expressed understanding and agreement with the plan of care. Continued skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> are indicated for ongoing monitoring of the patient's overall condition, dialysis access site, and adherence to medical and therapeutic regimens.
 Date of Order 11/03/2025 Orders Physician Face-to-Face Date: 10/20/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat HHA due to Hypertensive Heart And Chronic Kidney Disease With Heart Failure And With Stage 5 Chronic Kidney Disease, Or End Stage Renal Disease 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:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 11/03/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Maya Jaajah
1050 Key Pkwy Ste 102
Frederick, MD 21702
PHONE: 2402151138 FAX: 12402151140 NPI: 1104605674

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 : 10/20/2025

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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soc PT Eval Notes: OT Eval Notes: Physician Jaajah, Maya

SN Careplans

SN WK1: 2 (11/03/25-11/08/25) ,WK2: 2 (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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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: M2020 - Oral Med Management, M2102f - Patient Supervision, M1033 - Exhaustion, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal BS < 70/140 > mg/dL, limited endurance, limited strength, impaired speech, B0200 - Hearing Deficit, B1000 - Vision Deficit

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, glucose testing via monitor, monitor intake & output, coordinate/arrange for adequate patient supervision, coordinate/arrange resources for vision-impaired, 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, * 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 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 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, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, 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/CO2 alarms, 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

SN Goals

PATIENT-STATED GOAL: Increase endurance

GOALS
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 modification to manage blood condition including dietary changes
* bleeding precautions
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* low cholesterol dietary guidelines
* 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

patient/caregiver recalls
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* 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/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* 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
* 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

PT Careplans

PT WK1: 2 (11/03/25-11/08/25) ,WK2: 2 (11/09/25-11/15/25) ,WK3: 1 (11/16/25-11/22/25) ,WK4: 1 (11/23/25-11/29/25) ,WK5: 1 (11/30/25-12/06/25) ,WK6: 1 (12/07/25-12/13/25)

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: home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze.

PT Goals

PATIENT-STATED GOAL: I want to get stronger and to walk better

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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

11/03/2025

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Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., work simplification/energy conservation, dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention

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 - 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

* 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 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

OT Careplans

OT WK1: 1 (11/03/25-11/08/25) ,WK2: 1 (11/09/25-11/15/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, 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: cough/deep breathing exercises, work simplification/energy conservation

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, 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, Therapeutic exercise , Therapeutic activity , Therapeutic activity , to improve endurance , To improve endurance

OT Goals

PATIENT-STATED GOAL: To do exercises

GOALS
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

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

Therapeutic activity

To improve endurance

Therapeutic activity

Therapeutic exercise

to improve endurance

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/03/2025