Home Health Certification and Plan of Care

Order ID: 1150/14633

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01192282	12/04/2025	From: 12/04/2025 To: 02/01/2026	19335	217058

6. Patient's Name and Address

Joseph Fowlkes
1343 GLENWOOD AVENUE,
BALTIMORE, MD 21239-
443-850-8478

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 05/26/1948 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
D62.	Acute posthemorrhagic anemia	12/04/25

13. ICD	Other Pertinent Diagnoses	Date
E11.49	Type 2 diabetes w oth diabetic neurological complication	12/04/25
I10.	Essential (primary) hypertension	12/04/25
I48.0	Paroxysmal atrial fibrillation	12/04/25
I48.92	Unspecified atrial flutter	12/04/25
I69.398	Other sequelae of cerebral infarction	12/04/25
H54.7	Unspecified visual loss	12/04/25
G30.9	Alzheimer's disease unspecified	12/04/25
F02.A0	Dem in other dis classd elswhr mild w/o beh/psych/mood/anx	12/04/25
G21.9	Secondary parkinsonism unspecified	12/04/25
I45.10	Unspecified right bundle-branch block	12/04/25
D86.9	Sarcoidosis unspecified	12/04/25
N28.1	Cyst of kidney acquired	12/04/25
K86.2	Cyst of pancreas	12/04/25
E78.5	Hyperlipidemia unspecified	12/04/25
E04.1	Nontoxic single thyroid nodule	12/04/25
E55.9	Vitamin D deficiency unspecified	12/04/25
Z79.82	Long term (current) use of aspirin	12/04/25
Z79.01	Long term (current) use of anticoagulants	12/04/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	12/04/25
Z85.038	Personal history of malignant neoplasm of large intestine	12/04/25
Z85.46	Personal history of malignant neoplasm of prostate	12/04/25
Z90.49	Acquired absence of other specified parts of digestive tract	12/04/25

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

Lipitor - Atorvastatin Calcium 80 mg tablet, Take 1 tablet by mouth once a day
Cardizem Cd - Diltiazem Hydrochloride 240 mg,capsule take 1 capsule by mouth once a day
Aricept - Donepezil Hydrochloride 5 mg oral tablet by mouth at bedtime
Aricept - Donepezil Hydrochloride 10 mg, Oral tablet by mouth at bedtime When finished 5 mg, start 10 mg tablets
Pradaxa - Dabigatran Etexilate Mesylate 150 mg oral tablet, Take 2 tablet by mouth twice a day
Jardiance - Empagliflozin 12.5 mg,tablet by mouth once a day
Lantus Insulin - Insulin Glargine Recombinant 42 units subcutaneous once a day Insulin SEMGLEE
Immodium - Loperamide Hydrochloride 1 capsule by mouth as necessary Loose stool
Immodium - Loperamide Hydrochloride 1 capsule by mouth as necessary Loose stool
Extra Strength Tylenol - Acetaminophen 1 500mg by mouth as necessary
Capecitabine - Capecitabine 9 tablets by mouth twice a day 4 tablets by mouth in the morning and 5 tablets by mouth in the evening for 14 days(last day of first 14 is today 12-10-25) then off for 7 days. Then resume. Chemotherapy medication

14. DME and Supplies:
walker

15. Safety Measures:
, , bathroom safety, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
hydrochlorothiazide

18.A. Functional Limitations
None of the above

18.B. Activities Permitted
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: 1. Rarely, 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, HISTORY OF DEPRESSION: No

20. Prognosis: fair

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 Acute Posthemorrhagic Anemia , 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.

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 12/04/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Neelofar Wajahat
7141 Security Blvd
Baltimore, MD 21244
PHONE: 855-902-4974 FAX: 14108473396 NPI: 1083861181

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 : 11/21/2025

27. Attending Physician's Signature and Date Signed **12/10/2025**: 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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Clinical Condition Requiring Homecare:

The patient is a 77-year-old male with a significant past medical history of active colon cancer currently treated with oral chemotherapy, status post recent hospitalization on 10/31 for colon cancer with surgical resection and rectal bleeding, along with hypertension, hyperlipidemia, type 2 diabetes mellitus, atrial fibrillation/flutter, prior left cerebrovascular accident with residual right-sided weakness and foot drop, Alzheimer's disease, sarcoidosis, Parkinson's disease, and a history of prostate cancer. He resides in a two-story townhouse with 10 steps to enter, with the bedroom and bathroom located on the second floor, and lives with his grandson; his wife and daughter are actively involved in his care. At the time of assessment, the patient was alert and oriented to person and place but not to time, and he denied pain, shortness of breath, or chest pain. Physical assessment revealed lungs clear to auscultation, active bowel sounds, and no edema to the extremities. The patient ambulates independently within the home with a steady gait on level surfaces and is able to ambulate approximately 30 feet twice with close supervision due to right foot drop; he is able to negotiate 14 steps with the use of a handrail and supervision. Bed mobility is independent, and transfers to the toilet, chair, and bed are performed with supervision. He currently utilizes a rolling walker for uneven surfaces. The patient is considered homebound secondary to the significant effort required to leave the home, as evidenced by a Tinetti score of 16/28, indicating a high fall risk. Therapeutic exercises were initiated, and the patient tolerated 10 repetitions each of supine hip flexion, bridging, hook-lying rotation, straight leg raises, hip abduction, knee extension, and ankle pumps. Prior to hospitalization, the patient was independent with basic self-care, functional transfers, functional ambulation, simple meal preparation, and laundry, with his wife and daughter assisting with shopping and medical appointments. Currently, he remains independent with self-care, functional transfers, and functional ambulation, and no additional skilled occupational therapy services are recommended at this time. Medication management is performed by the patient's daughter, who organizes medications weekly; however, all medications, including discontinued ones, are kept within the patient's reach, and the patient is unaware of which medications to take. The family was educated and encouraged to remove inactive medications and store them separately to reduce the risk of medication errors and promote safety.
 Date of Order 12/04/2025 Orders Physician Face-to-Face Date: 11/21/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Acute Posthemorrhagic Anemia 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 Wajahat, Neelofar

SN Careplans

SN WK1: 1 (12/04/25-12/06/25) ,WK2: 2 (12/07/25-12/13/25) ,WK3: 2 (12/14/25-12/20/25) ,WK4: 1 (12/21/25-12/27/25)

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, blood sugar < 60 > 300

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M1745 - Behavioral Issues, M2020 - Oral Med Management, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, tarry/bloody stools

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, * lifestyle modification to manage blood condition including dietary changes bleeding precautions, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: I want to stay home

GOALS
patient/caregiver recalls
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* 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 keep home safe for patient with dementia
* coping strategies for the caregiver
* 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
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

12/04/2025

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PT WK1: 1 (12/04/25-12/06/25) ,WK3: 1 (12/14/25-12/20/25) ,WK4: 1 (12/21/25-12/27/25) ,WK5: 1 (12/28/25-01/03/26) ,WK6: 1 (01/04/26-01/10/26) ,WK7: 1 (01/11/26-01/17/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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 : Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, Dynamic and static standing balance training, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

PATIENT-STATED GOAL: Be able to walk on all surfaces by myself

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

OT Careplans

OT WK1: 6 (12/04/25-12/06/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, 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 : Medication reviewed with patient and caregiver. No issues noted

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

OT Goals

PATIENT-STATED GOAL: Evaluation only

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/04/2025