Home Health Certification and Plan of Care

Order ID: 1150/14606

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3XM2DG4DT82	12/03/2025	From: 12/03/2025 To: 01/31/2026	19790	217058

6. Patient's Name and Address
Larry Smith
2825 Indiana St,
BALTIMORE, MD 21230-
410-501-9738

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 07/28/1956 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
G93.40	Encephalopathy unspecified	12/03/25

13. ICD	Other Pertinent Diagnoses	Date
E11.65	Type 2 diabetes mellitus with hyperglycemia	12/03/25
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	12/03/25
I50.20	Unspecified systolic (congestive) heart failure	12/03/25
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	12/03/25
N18.31	Chronic kidney disease stage 3a	12/03/25
D63.1	Anemia in chronic kidney disease	12/03/25
I69.351	Hemiplga following cerebral infrc aff right dominant side	12/03/25
I69.322	Dysarthria following cerebral infarction	12/03/25
S03.2XXD	Dislocation of tooth subsequent encounter	12/03/25
S00.531D	Contusion of lip subsequent encounter	12/03/25
F03.90	Unsp dementia unsp severity without beh/psych/mood/anx	12/03/25
E78.5	Hyperlipidemia unspecified	12/03/25
E87.1	Hypo-osmolality and hyponatremia	12/03/25
E87.5	Hyperkalemia	12/03/25
R79.89	Other specified abnormal findings of blood chemistry	12/03/25
Z79.82	Long term (current) use of aspirin	12/03/25
Z79.899	Other long term (current) drug therapy	12/03/25
Z79.4	Long term (current) use of insulin	12/03/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	12/03/25
Z91.81	History of falling	12/03/25

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

Aspirin - Aspirin 81 mg tablet, Take 1 tablet by mouth once a day
Atorvastatin - Atorvastatin Calcium 40 mg oral tablet Take 1 tablet by mouth once a day
Calcitriol - Calcitriol l 0.25 mcg oral capsule, Take 1 capsule by mouth every other day
Carvedilol - Carvedilol 6.25 mg oral tablet , take 1 tab by mouth twice a day
docusate-senna 50 mg-8.6 mg oral tablet, take 2 tablet by mouth twice a day PRN constipation
Jardiance - Empagliflozin 10 mg oral tablet, Take 1 tab by mouth once a day
Gabapentin - Gabapentin 300 mg oral capsule , Take 1 capsule by mouth twice a day
Humalog - Insulin Lispro Recombinant 100 units/mL injectable solution intravenous three times a day Special Instructions
150 - 199 - 1 unit Insulin
200 - 249 - 2 units Insulin
250 - 299 - 3 units Insulin
300 - 349 - 4 units Insulin
greater than 349 - 5 units Insulin
Basaglar - Insulin Glargine (insulin glargine 100 units/mL subcutaneous solution)8 units intravenous once a day
Metformin - Metformin Hydrochloride 500 mg oral tablet , take 1 tablet by mouth twice a day
Risperidone - Risperidone 1 mg oral tablet Take 1 tablet by mouth twice a day
sacubitril-valsartan Entresto 24 mg-26 mg Tab, take 1 tablet by mouth twice a day
Calcium With Vitamin D - Calcium Acetate gummie by mouth once a day supplement

14. DME and Supplies:
wheelchair, walker, diabetic supplies, bath bench

15. Safety Measures:
bathroom safety, , aspiration precautions, activity supervision, ambulates with assistance, ambulates with device, diabetic precautions, , no bp right arm, , supervision at all times, wheelchair precautions, walker precautions

16. Nutrition:
low sodium, cardiac diet, diabetic

17. Allergies:
no known allergies

18.A. Functional Limitations
Bowel/Bladder Incontinence, Endurance, Paralysis, Speech, Ambulation

18.B. Activities Permitted
Wheelchair, Walker, 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, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

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 Encephalopathy Unspecified, 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 69-year-old male with an extensive past medical history significant for recurrent falls, dementia, type 2 diabetes mellitus on long-term insulin therapy, hypertension, hyperlipidemia, congestive heart failure, chronic kidney disease, anemia, prior cerebrovascular accident with resulting right-sided hemiplegia, right foot drop, dysarthria, hyponatremia, hypercalcemia, and increased overall fall risk. He was recently hospitalized following a fall resulting in a dislocated tooth and contusion of the lip secondary to a transient ischemic attack. He is homebound due to significant physical limitations and the taxing effort required to leave the home, as evidenced by a Tinetti score of 2/28. The patient resides in a multi-level row house with seven steps to enter and the bedroom and bathroom located on the second floor; he currently lives with family/friends and receives personal care assistance through Home Centris. The primary caregiver is Patricia Williams, with an additional caregiver assisting as needed, and all consents were reviewed with both the patient and caregiver. Medications were reviewed with the caregiver and are administered as directed; senna/docusate is given as needed. The patient and caregiver report no falls since discharge approximately one and a half weeks ago. The patient reports good appetite and denies pain, dysuria, abdominal discomfort, nausea, or vomiting. There is some discrepancy in bowel history, as the patient reports his last bowel movement was one week ago, while the caregiver reports a bowel movement occurred yesterday. No abnormal bleeding was noted. The patient has a Dexcom G7 continuous glucose monitor applied to the upper right arm, with a

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 12/03/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
John Allen
419 W Redwood St Ste 600
Baltimore, MD 21201
PHONE: 667-214-1515 FAX: 14103283577 NPI: 1023436839

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 : 11/18/2025

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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random post-breakfast blood glucose of 194 mg/dL; caregivers are aware of dietary and diabetic management recommendations. On assessment, lungs were clear to auscultation, and the patient denied chest or urinary pain. Functionally, the patient requires significant assistance for mobility and activities of daily living: he transfers from recliner to stand with moderate assistance of two persons, stand-pivots to the bed with minimal assistance using a walker, and requires minimal assistance with bed mobility, particularly for lower extremity management. He is able to stand at the walker for approximately one minute with minimal assistance of two persons and tolerates static standing for about 30 seconds. Gait, stair negotiation, and outdoor mobility were not assessed due to safety concerns. Upper extremity strength is approximately 4-/5 bilaterally with noted deficits in grip strength and fine motor coordination, resulting in the need for assistance with bathing and dressing. The patient was observed pushing himself up in bed with assistance and was repeatedly instructed not to attempt transfers without notifying a caregiver; he was able to correctly repeat these safety instructions. The patient's stated goal for home health services is "to be able to stand for a period of time." Education was reinforced with both patient and caregivers regarding fall prevention, safe transfer techniques, supervision at all times, bowel regimen monitoring, and diabetic management. Based on the patient's significant functional impairments, high fall risk, and complex medical history, he would benefit from continued skilled nursing and home therapy services to improve strength, functional mobility, transfer safety, and overall independence, with consideration for a first-floor living setup to enhance safety.
 Date of Order 12/03/2025 Orders Physician Face-to-Face Date: 11/18/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Encephalopathy Unspecified 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 Allen, John

SN Careplans

SN WK1: 1 (12/03/25-12/06/25) ,WK2: 1 (12/07/25-12/13/25) ,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)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M1745 - Behavioral Issues, M1700 - Cognition, meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, dizziness/syncope, abnormal blood pressure, abn cholesterol > 200 mg/dL, M1033 - Exhaustion, abnormal BS < 70/140 > mg/dL, muscle weakness, limited range of motion, limited endurance, limited strength, Pain Interference with ADLs, impaired speech, daytime fatigue, weak hand grips, balance deficit, B1000 - Vision Deficit

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor, monitor intake & output, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired

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 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver, 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, * 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

SN Goals

PATIENT-STATED GOAL: to be able to stand on his own

GOALS
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
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* recalls related medication(s) purpose, schedule

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
* 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
* how to keep home safe for patient with dementia
* coping strategies for the caregiver
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* low cholesterol dietary guidelines
* 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

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
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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 patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

* 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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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
* 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 patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (12/03/25-12/06/25) ,WK2: 1 (12/07/25-12/13/25) ,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) ,WK8: 1 (01/18/26-01/24/26) ,WK9: 1 (01/25/26-01/31/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, 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 : Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Sitting knee extension, ankle pumps. Standing knee flexion ,hip abduction, squats, Bed mobility training , Family training with caregiver and wife. , Sit with head erect 2 min instead of posterior neck parallel to the floor. , cough/deep breathing exercises, 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, * 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, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 04. Supervision or touching assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 03. Partial/moderate assistance, Walk 50 ft with 2 Turns - 03. Partial/moderate assistance, Walk 150 Feet - 03. Partial/moderate assistance, 1 - Step (curb) - 03. Partial/moderate assistance, 4 Steps - 03. Partial/moderate assistance, 12 Steps - 03. Partial/moderate assistance, Picking Up Object - 03. Partial/moderate assistance

PT Goals

PATIENT-STATED GOAL: To be able to walk in the house

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

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

Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Toilet Transfer - 04. Supervision or touching assistance

Car Transfer - 04. Supervision or touching assistance

Walk 10 Feet - 03. Partial/moderate assistance

Walk 50 ft with 2 Turns - 03. Partial/moderate assistance

Walk 150 Feet - 03. Partial/moderate assistance

1 - Step (curb) - 03. Partial/moderate assistance

4 Steps - 03. Partial/moderate assistance

12 Steps - 03. Partial/moderate assistance

Picking Up Object - 03. Partial/moderate assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

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OT Careplans

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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: ADLs , Patient/caregiver recalls related purpose and schedule of medications: Medications review, equipment training, work simplification/energy conservation, transfers training, therapeutic exercises

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 - 05. Setup or clean-up assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 03. Partial/moderate assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent, Patient will demonstrate improved bilateral upper extremity muscle strength from 4-/5 mmt to 4+/5 mmt to improve ADLs and transfers within 6 wks

OT Goals

PATIENT-STATED GOAL: Patient wants to get stronger and stand up longer

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 - 05. Setup or clean-up assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 03. Partial/moderate assistance

Shower/Bathe Self - 04. Supervision or touching assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 06. Independent

Patient will demonstrate improved bilateral upper extremity muscle strength from 4-/5 mmt to 4+/5 mmt to improve ADLs and transfers within 6 wks

Signature of Physician:	Date
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