Home Health Certification and Plan of Care

Order ID: 1150/14752

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3P80KP0XN07	12/09/2025	From: 12/09/2025 To: 02/06/2026	20231	217058

6. Patient's Name and Address
Wayne Scott
2305 Garrett Ave,
Baltimore, MD 21218-
410-243-5812

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 01/11/1947 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I11.0	Hypertensive heart disease with heart failure	12/09/25

13. ICD	Other Pertinent Diagnoses	Date
I50.32	Chronic diastolic (congestive) heart failure	12/09/25
I48.0	Paroxysmal atrial fibrillation	12/09/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	12/09/25
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	12/09/25
F32.A	Depression unspecified	12/09/25
G47.00	Insomnia unspecified	12/09/25
M1A.9XX1	Chronic gout unspecified with tophus (tophi)	12/09/25
G89.4	Chronic pain syndrome	12/09/25
I48.92	Unspecified atrial flutter	12/09/25
B18.2	Chronic viral hepatitis C	12/09/25
D69.6	Thrombocytopenia unspecified	12/09/25
D64.9	Anemia unspecified	12/09/25
Z79.01	Long term (current) use of anticoagulants	12/09/25
Z87.891	Personal history of nicotine dependence	12/09/25
Z91.81	History of falling	12/09/25

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

Acetaminophen - Acetaminophen 500 MG, Give 2 tablet by mouth every 8 hours Give 2 tablet by mouth every 8 hours for pain
Allopurinol - Allopurinol 100 mg 100mg , Give 1 tablet by mouth once a day Give 1
tablet by mouth one time a day for Gout

14. DME and Supplies:
wheelchair, rolling walker, walker, reacher, commode, cane

15. Safety Measures:
wheelchair precautions, standard precautions, fall precautions, ambulates with device, walker precautions, medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, activity supervision

16. Nutrition:
cardiac diet

17. Allergies:
lisinopril

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Cane, Walker, Up As Tolerated, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:
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.

22.B.Discharge Plans
patient will be responsible for managing treatment

Homebound status:
Due to diagnosis of Hypertensive heart disease with heart failure, 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 78-year-old male admitted to home care services for skilled nursing, physical therapy, and occupational therapy following a recent inpatient hospitalization related to multiple falls. His past medical history is significant for heart failure, atrial fibrillation on Eliquis, coronary artery disease, hypertension, benign prostatic hyperplasia, chronic tophaceous gout, depression, chronic hepatitis C (treated), and a history of recurrent falls. Skilled nursing services are ordered at a frequency of 2 visits per week for 2 weeks, then 1 visit per week for 6 weeks, with PT and OT evaluations completed. The patient reports limited assistance from his stepsons and is currently residing on the first floor of his home, using the kitchen area for personal care due to inability to access the upstairs bedroom and bathroom. At start of care, only allopurinol was available in the home; the primary care provider is aware, prescriptions have been sent to Express Scripts for delivery, and skilled nursing will follow up on medication delivery at the next visit. The patient is alert and oriented 3 and reports severe bilateral ankle and foot pain rated 9/10. He denies shortness of breath, lung sounds are clear, appetite is good, and last bowel movement was reported on Sunday. Examination revealed bilateral lower extremity hyperpigmentation with significant edema (+3 to +4), unsteady gait, and a scabbed area on the left knee from a prior fall, left open to air. A walker is present in the home. Skilled nursing reviewed medication management and emphasized the importance of taking all medications as prescribed and elevating the lower extremities as much as possible, though elevation is limited by the home environment; the patient was receptive but requires continued education. Physical therapy evaluation identified decreased bilateral lower extremity strength (3-/5), requiring contact guard assistance for transfers and short-distance ambulation with a rolling walker, with mobility limited by pain and edema and inability to negotiate stairs. The patient was encouraged to contact his physician regarding a telehealth visit to review medications and obtain necessary prescriptions. Occupational therapy evaluation noted decreased standing balance, tolerance, bilateral upper extremity strength, and activity tolerance, resulting in reduced independence with self-care, functional transfers, and mobility, as well as inability to manage the 12 stairs to the upstairs bedroom and bathroom. The patient would benefit from continued skilled SN, PT, and OT services to address medical management, improve strength, balance, safety, and functional independence, and facilitate return toward his prior level of function.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> <p

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 12/09/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Shoaib Hashmi
821 N Eutaw St
Baltimore, MD 21201
PHONE: (410) 383-2072 FAX: 14103830054 NPI: 1821191412

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 : 11/28/2025

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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class="MsoNoSpacing">12/09/2025<o:p></o:p> Order<o:p></o:p> Physician Face-to-Face Date: 11/28/2025
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Hypertensive heart disease with heart failure
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval Notes:
 OT Eval Notes:<o:p></o:p> Physician: Hashmi, Shoaib

SN Careplans

SN WK1: 1 (12/09/25-12/13/25) ,WK2: 1 (12/14/25-12/20/25) ,WK3: 1 (12/21/25-12/27/25) ,WK4: 1 (12/28/25-01/03/26)

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

CAREGIVER: 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, Home Safety, M2020 - Oral Med Management, Home Safety, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, meal preparation, M2102c - Med Admin, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, limited range of motion, swelling of affected area, limited strength, limited endurance, Pain Effect on Sleep, balance deficit, Pain Interference with ADLs, obesity, rough/scaly/cracked skin, #1 - Other - Anterior Left Knee - left knee scabbed area open to air

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver, cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: KEEP LEFT KNEE SCABBED AREA OPEN TO AIR, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, * 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * how to manage gout flare-ups including non-medical pain relief dietary modifications, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient living environment has safe floor coverings, patient's living environment is clean/uncluttered, 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

SN Goals

PATIENT-STATED GOAL: I WANT OT BE ABLE TO GET AROUND BETTER AND TO GET MY MEDICATIONS

GOALS
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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to manage gout flare-ups including non-medical pain relief
* dietary modifications
* 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
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* 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
* 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
* 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

patient living environment has safe floor coverings

patient's living environment is clean/uncluttered

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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/09/2025

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PT Careplans

PT WK1: 1 (12/09/25-12/13/25) ,WK3: 1 (12/21/25-12/27/25) ,WK4: 1 (12/28/25-01/03/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, 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: Medication Review: - medications reviewed with patient/caregiver, dynamic standing balance exercises, gait training on uneven surfaces, gait training/stair training, transfers training, therapeutic exercises

TEACH PATIENT/CAREGIVER: * 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 - 05. Setup or clean-up assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Medication Review

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

GOALS
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 - 05. Setup or clean-up assistance

Car Transfer - 04. Supervision or touching assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Medication Review

OT Careplans

OT WK1: 1 (12/09/25-12/13/25) ,WK2: 1 (12/14/25-12/20/25) ,WK4: 1 (12/28/25-01/03/26)

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: Medication Review : Medication reviewed with patient , cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation, transfers training, assist with bathing, assist with lower body dressing, assist with upper body dressing, 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 - 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: Get to the bathroom

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

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
12/09/2025