Home Health Certification and Plan of Care

Order ID: 1150/15391

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
97268856	01/10/2026	From: 01/10/2026 To: 03/10/2026	21302	217058

6. Patient's Name and Address

Terrence Williams
5448 Old Court Rd apt. 201,
Randallstown, MD 21133-
443-522-7522

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 04/08/1982 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z48.812	Encntr for surgical aftcr following surgery on the circ sys	01/10/26

13. ICD	Other Pertinent Diagnoses	Date
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	01/10/26
Z95.1	Presence of aortocoronary bypass graft	01/10/26
I21.4	Non-ST elevation (NSTEMI) myocardial infarction	01/10/26
I10.	Essential (primary) hypertension	01/10/26
E11.9	Type 2 diabetes mellitus without complications	01/10/26
E78.5	Hyperlipidemia unspecified	01/10/26
J45.20	Mild intermittent asthma uncomplicated	01/10/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	01/10/26
F17.210	Nicotine dependence cigarettes uncomplicated	01/10/26
E66.9	Obesity unspecified	01/10/26
Z68.38	Body mass index [BMI] 38.0-38.9 adult	01/10/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	01/10/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	01/10/26
Z79.82	Long term (current) use of aspirin	01/10/26

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

Acetaminophen - Acetaminophen 500 mg / 1 Tablet by mouth every 6 hours Take 2 tablets by mouth every 6 hours for 7 days. And then take as needed for pain
Commonly known as: TYLENOL
Metformin - Metformin Hydrochloride 1000mg/ 1 Tablet by mouth twice a day With meals. Start by taking 1 tab daily, and increase after a week.
DM
Commonly known as: GLUCOPHAGE
8-Hour Bayer - Aspirin 81MG chewable tablet by mouth once a day CAD
Atorvastatin - Atorvastatin Calcium 80 mg / 1 Tablet by mouth once a day
Commonly known as: LIPITOR
CHOLESTEROL
Clopidogrel - Clopidogrel 75 mg 75 mg1 Tablet by mouth once a day
Commonly known as: PLAVIX. Start taking on: January 9, 2026
BLOOD THINNER
Oxycodone Immediate Release Tablet 5 mg / 1 Tablet by mouth every 6 hours As needed For Breakthrough Pain.
Toprol-Xl - Metoprolol Succinate eq 50 mg tartrate eq 50 mg tartrate1 Tablet by mouth once a day a fib
Pepcid - Famotidine 40 mg 40 mg1 Tablet by mouth once a day stomach
Furosemide - Furosemide 40 mg 40 mg1 Tablet by mouth once a day for 10 days. Commonly known as: Lasix
fluid pill
Senna - Senna 08.6 mg / 1 Tablet by mouth twice a day as needed for Constipation. Commonly known as: SENOKOT

14. DME and Supplies:
wound care supplies, diabetic supplies

15. Safety Measures:
diabetic precautions, , transfer with assist, cardiac precautions,

16. Nutrition:
cardiac diet

17. Allergies:
ibuprofen

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
Exercises Prescribed, Up As Tolerated, STERNAL PRECAUTIONS

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, 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 Encounter For Surgical Aftercare Following Surgery On The Circulatory System, 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 43-year-old male recently admitted to the hospital for coronary artery disease status post ST-elevation myocardial infarction, who subsequently underwent coronary artery bypass grafting (CABG). His past medical history is significant for obesity, type 2 diabetes mellitus, essential hypertension, hyperlipidemia, intermittent asthma, obstructive sleep apnea without CPAP use, and prior coronary artery disease with percutaneous coronary intervention to the left circumflex artery in 2023. He resides in an apartment with his girlfriend, who provides assistance with all activities of daily living and instrumental activities of daily living. Skilled nursing services are ordered at a frequency of 1 visit per week for 1 week, 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> per week for 1 week, and 3 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> per week for 1 week, with physical therapy and occupational therapy evaluations also ordered. At the skilled nursing visit, the patient was alert and oriented to person, place, and time. He reported pain rated at 3/10 and stated he took acetaminophen 500 mg, two tablets, approximately 30 minutes prior to the visit. He denied shortness of breath; however, lung sounds were diminished throughout. Appetite was reported as good, and the patient stated his last bowel movement occurred on the day of <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>. Inspection of surgical sites revealed a closed midline sternal incision measuring 15.5 cm in length, three former chest drain sites covered with dry dressings, a closed right inner lower leg incision measuring 4.0 cm, and a closed inner upper thigh incision measuring 0.5 cm. No signs or symptoms of infection were observed at any incision sites. The patient demonstrated decreased endurance but was ambulating without the use of an assistive device. Skilled nursing reviewed all medications with the patient and his girlfriend, including dosage, frequency, indications, and pertinent side effects. Disease process education related to coronary artery disease was initiated, and comprehensive postoperative teaching related to CABG was provided. Both the patient and his girlfriend verbalized understanding of the education provided. Physical therapy evaluation noted that prior to hospitalization, the patient was independent with ambulation without an assistive device and was working full time. At the time of evaluation, the patient demonstrated decreased bilateral lower extremity strength at approximately 3+/5 on manual muscle testing and required supervision for transfers and short-distance ambulation without an assistive device. Functional mobility was limited by fatigue and sternal pain. Physical therapy initiated therapeutic exercises for the bilateral lower extremities with options for both seated and standing performance based on the patient's energy level. The patient would benefit from continued skilled physical therapy services to improve strength, balance, endurance, and overall safety and independence with functional mobility in order to return to his prior level of function. Occupational therapy <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> indicated that the patient requires contact guard to standby assistance for bathing and dressing tasks, with increased time

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/10/2026

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 : 01/08/2026

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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needed to complete activities due to decreased activity tolerance and the need for multiple rest breaks. He was instructed on the use of a tub chair to improve safety during bathing, and he verbalized understanding. The patient requires standby assistance for sit-to-stand and toilet transfers, with verbal cues needed for proper limb placement. He demonstrated bilateral upper extremity weakness and was educated on recognizing his physical limitations and the importance of taking rest breaks as needed to prevent overexertion. The patient verbalized understanding of all education provided.
 Date of Order 01/10/2026 Orders Physician Face-to-Face Date: 01/08/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Encounter For Surgical Aftercare Following Surgery On The Circulatory System 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 (01/10/26-01/10/26) ,WK2: 1 (01/11/26-01/17/26) ,WK3: 2 (01/18/26-01/24/26) ,WK4: 1 (01/25/26-01/31/26) ,WK5: 1 (02/01/26-02/07/26) ,WK6: 1 (02/08/26-02/14/26)

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

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (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, 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, lung sounds not clear, dependent edema, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, #1 - Other - Other - MIDLINE STERNUM - CLOSED ML STERNAL INCISION OPEN TO AIR, #2 - Other - Other - RIGHT LOWER LEG INNER ASPECT - CLOSED INNER RIGHT LOWER LEG OPEN TO AIR NO DRAINAGE NOTED, #3 - Other - Other - RIGHT INNER THIGH - OPEN TO AIR NO DRAINAGE NOTED

PROCEDURES: physician-ordered wound care: #2 - Other - Other - RIGHT LOWER LEG INNER ASPECT - CLOSED INNER RIGHT LOWER LEG OPEN TO AIR NO DRAINAGE NOTED, physician-ordered wound care: #1 - Other - Other - MIDLINE STERNUM - CLOSED ML STERNAL INCISIONOPEN TO AIR: OPEN TO AIR, physician-ordered wound care: #3 - Other - Other - RIGHT INNER THIGH - OPEN TO AIRNO DRAINAGE NOTED: OPEN TO AIR, Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: To sternal and right lower leg surgical wound sites: Shower daily and clean incisions with soap and water, pat dry with a clean washcloth. (do not rub). Avoid using very hot water. Do not apply anything to the incision sites, including powders or lotions.

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 medicatio, * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, 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 relaxatio, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: I WANT TO FEEL BETTER

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
* 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 medicatio

patient/caregiver recalls
* lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* 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 relaxatio

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

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 1 (01/11/26-01/17/26) ,WK3: 1 (01/18/26-01/24/26) ,WK4: 1 (01/25/26-01/31/26) ,WK5: 1 (02/01/26-02/07/26) ,WK6: 1 (02/08/26-02/14/26)

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, cough/deep breathing exercises, gait training on uneven surfaces, gait training/stair training, transfers training

PT Goals

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

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

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/10/2026

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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 medicatio, * 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 relaxatio, 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, Medication Review, Medication Review

* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medicatio

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 relaxatio

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

Medication Review

Medication Review

OT Careplans

OT WK1: 1 (01/11/2026 - 01/17/2026), WK2: 1 (01/18/2026 - 01/24/2026), WK3: 1 (01/25/2026 - 01/31/2026), WK4: 1 (02/01/2026 - 02/07/2026)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, 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: ADLs , Patient/caregiver recalls related purpose and schedule of medications: Medications review , therapeutic exercises, work simplification/energy conservation, 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 medicatio, * 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 relaxatio, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Patient wants to get stronger and for the pressure in chest to go away

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 medicatio

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 relaxatio

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/10/2026