Home Health Certification and Plan of Care

Order ID: 1150/14678

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3ME1DH5XE25	12/04/2025	From: 12/04/2025 To: 02/01/2026	20167	217058

6. Patient's Name and Address
James Ruth
446 Stemmers Run Road,
Essex, MD 21221-
443-554-4364

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 06/19/1960 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
G89.4	Chronic pain syndrome	12/04/25

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	12/04/25
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	12/04/25
M15.9	Polyosteoarthritis unspecified	12/04/25
S72.91XD	Unsp fracture of right femur subs for clos fx w routn heal	12/04/25
S62.102D	Fx unsp carpal bone left wrist subs for fx w routn heal	12/04/25
I48.91	Unspecified atrial fibrillation	12/04/25
G47.30	Sleep apnea unspecified	12/04/25
G25.81	Restless legs syndrome	12/04/25
K58.1	Irritable bowel syndrome with constipation	12/04/25
M54.2	Cervicalgia (M54.2)	12/04/25
K21.9	Gastro-esophageal reflux disease without esophagitis	12/04/25
F33.9	Major depressive disorder recurrent unspecified	12/04/25
E66.01	Morbid (severe) obesity due to excess calories	12/04/25
Z68.39	Body mass index [BMI] 39.0-39.9 adult	12/04/25
Z79.01	Long term (current) use of anticoagulants	12/04/25
Z90.49	Acquired absence of other specified parts of digestive tract	12/04/25
Z87.891	Personal history of nicotine dependence	12/04/25
Z96.651	Presence of right artificial knee joint	12/04/25
Z91.81	History of falling	12/04/25

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

Extra Strength Tylenol - Acetaminophen 500mg, take 2 tablets by mouth three times a day Pain
Amiodarone Hydrochloride - Amiodarone Hydrochloride 200 mg Take 1 tablet, by mouth in the morning Heart
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg 0.4 MG CAPSULE by mouth once a day BPH
Vitamin D2 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1.25mg, take 1 capsule by mouth Monthly On the 5th of every month for Vitamin D deficiency
Furosemide - Furosemide 20 MG TABLET, by mouth in the morning Fluid pill
BUPRENORPHINE-NALOX 8-2MG FILM,Tablet by mouth every 8 hours Pain
Metoprolol Succinate - Metoprolol Succinate eq 25 mg tartrate 25 MG TAB, by mouth at bedtime HTN. Hold for SBP less than 110 or HR is less than 60
Jantoven - Warfarin Sodium 4 MG TABLET by mouth once a day Anticoagulant
Miralax - Polyethylene Glycol 3350 17gm by mouth once a day For constipation

14. DME and Supplies:
walker, wheelchair, commode, hospital bed

15. Safety Measures:
standard precautions, diabetic precautions, fall precautions, medication safety, ,

16. Nutrition:
low sodium

17. Allergies:
heparin mushroom seasonal allergy stress test medication

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
No Restrictions

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: 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: 1. Dependent - A helper completed all the activities for the patient.

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

Homebound status:
Due to diagnosis of Chronic pain syndrome, 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 65-year-old male with a medical history significant for arthritis, GERD, hypertension, and type 2 diabetes. He reports falling at home, resulting in a right femur and right wrist fracture, followed by a stay in a rehab facility and subsequent home PT/OT services, which were later discontinued by his insurance. He is alert and oriented 4, uses a wheelchair for mobility, and is able to transfer from bed to wheelchair, though his goal is to regain the ability to navigate his home with an assistive device. The patient reports knee instability when attempting to stand and is requesting support braces. Vital signs were within normal limits, and no respiratory distress was noted. He resides with his son in a cluttered and unclean basement area where the bathroom is nonfunctional; he receives sponge baths and uses a bedside commode with assistance from his son, who serves as his primary caregiver. The patient demonstrates decreased standing balance, standing tolerance, upper-extremity strength, and overall activity tolerance, impacting self-care, functional transfers, and mobility. Skilled OT services are recommended to address these deficits and support progress toward his prior level of function.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 12/04/2025<o:p></o:p> Order<o:p></o:p> Physician Face-to-Face Date: 11/26/2025
 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat DX: Chronic pain syndrome
 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 - PT Notes:
 OT Eval Notes:<o:p></o:p> Physician: Rollins Mrs., Lawanda

SN Careplans

SN Goals

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
Lawanda Rollins Mrs.
8831 Satyr Hill Rd Ste 100
Parkville, MD 21234
PHONE: 443-946-1896 FAX: 14434952902 NPI: 1003384165

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 : 11/26/2025

27. Attending Physician's Signature and Date Signed **12/11/2025** 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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6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
James Ruth 446 Stemmers Run Road, Essex, MD 21221- 443-554-4364	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

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

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, Home Safety, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, muscle weakness, Pain Effect on Sleep, Pain Interference with ADLs, daytime fatigue, balance deficit

PROCEDURES: Medication Review: Medication reviewed with patient /caregiver., cough/deep breathing 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, * 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's living environment is clean/uncluttered

PATIENT-STATED GOAL: To navigate the house with an assistive device.

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

patient's living environment is clean/uncluttered

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

OT Careplans

OT 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)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, 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: Medication Review : Medication reviewed with patient and caregiver , equipment training, work simplification/energy conservation, transfers training, assist with bathing, 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, * 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, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: Get in the shower

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

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

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/04/2025