Home Health Certification and Plan of Care

Order ID: 1150/15559

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01201812	01/19/2026	From: 01/19/2026 To: 03/19/2026	21568	217058

6. Patient's Name and Address

Marvin Hodges
540 Temperence Hill Way,
HAVRE DE GRACE, MD 21078-
667-201-4002

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 11/27/1942 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
L89.152	Pressure ulcer of sacral region stage 2	01/19/26

13. ICD	Other Pertinent Diagnoses	Date
I48.0	Paroxysmal atrial fibrillation	01/19/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	01/19/26
I50.30	Unspecified diastolic (congestive) heart failure	01/19/26
N18.32	Chronic kidney disease stage 3b	01/19/26
E11.69	Type 2 diabetes mellitus with other specified complication	01/19/26
E78.2	Mixed hyperlipidemia	01/19/26
J44.9	Chronic obstructive pulmonary disease unspecified	01/19/26
G89.29	Other chronic pain	01/19/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	01/19/26
I27.20	Pulmonary hypertension unspecified	01/19/26
I38.	Endocarditis valve unspecified	01/19/26
I44.7	Left bundle-branch block unspecified	01/19/26
M19.90	Unspecified osteoarthritis unspecified site	01/19/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	01/19/26
E66.01	Morbid (severe) obesity due to excess calories	01/19/26
Z68.36	Body mass index [BMI] 36.0-36.9 adult	01/19/26
Z79.01	Long term (current) use of anticoagulants	01/19/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	01/19/26
Z91.81	History of falling	01/19/26

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

Norvasc - Amlodipine Besylate eq 10 mg base 1 Tablet by mouth once a day
Cymbalta - Duloxetine Hydrochloride eq 30 mg base 1 Capsule by mouth once a day
Timoptic - Timolol Maleate eq 0.5 perc base - both eyes once a day
Nizoral - Ketoconazole 2 perc - threee times per week APPLY TO SCALP and face three times weekly. LEAVE ON FOR 5 MINS, THEN WASH OFF.
Neurontin - Gabapentin 600 mg 1 Tablet by mouth three times a day
Jardiance - Empagliflozin 25 mg / 1 Tablet by mouth once a day Take half tablet by mouth daily
Cozaar - Losartan Potassium 50 mg 1 Tablet by mouth once a day
Pradaxa - Dabigatran Etexilate Mesylate 150 mg 1 Capsule by mouth every 12 hours
Vitamins A-C-E-Zinc-Copper (PRESERVISION AREDS) 4,296 mcg-226 mg-90 mg Oral Cap by mouth twice a day
Lipitor - Atorvastatin Calcium eq 40 mg base 1 Tablet by mouth once a day for cholesterol and heart protection
Lopressor - Metoprolol Tartrate 25 mg / 1 Tablet by mouth twice a day Take 1 tablet by mouth 2 times a day (Patient taking differently: Take 25 mg by mouth daily)
Lasix - Furosemide 10 mg/ml 60ml intravenous once a day Chesapeake infusion company to inject 60ml Lasix daily in patient's left arm port until patient is euvilemic
Desitin - Desitin Hand full topical as necessary Apply cream liberally to buttocks every brief change or toileting for skin breakdown related to incontinence

14. DME and Supplies:

bath bench, hand held shower, rolling walker, wheelchair, walker, grab bars, commode, wound care supplies, cane, 4 wheeled walker, Stair lift

15. Safety Measures:

emergency phone # clearly displayed, walker precautions, smoke detectors , bathroom safety, , ambulates with device, ambulates with assistance, hand rails, , wheelchair precautions, transfer with assist, supervision at all times, , , , activity supervision

16. Nutrition:

fluid restriction, low sodium, Fluid restriction of 6 cups per day which is 1.42 liters

17. Allergies:

nitro ace inhibitors adhesive tape aldactone pepper tamsulosin hydrochloride

18.A. Functional Limitations

Ambulation, Bowel/Bladder Incontinence, Endurance

18.B. Activities Permitted

Wheelchair, Transfer bed/Chair, Exercises Prescribed, Walker, Up As Tolerated

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: 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

family/caregiver will be responsible for managing treatment

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 01/19/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Sonia Sharma
3400 Box Hill Center Dr
Abingdon, 0 21009
PHONE: 410-515-5440 FAX: NPI: 1336595925

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 : 01/15/2026

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.

Home Health Certification and Plan of Care

Order ID: 1150/15559

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01201812	01/19/2026	From: 01/19/2026 To: 03/19/2026	21568	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Marvin Hodges 540 Temperence Hill Way, HAVRE DE GRACE, MD 21078- 667-201-4002	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Homebound status: Due to diagnosis of Pressure Ulcer Of Sacral Region Stage 2, 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 an 87-year-old male with a significant past medical history including congestive heart failure, hypertension, hyperlipidemia, atrial fibrillation, obstructive sleep apnea not managed with CPAP, valvular regurgitation, chronic kidney disease stage III, mild pulmonary hypertension, and osteoarthritis, who was recently hospitalized following a fall at home associated with lower extremity swelling. The patient reported standing up from the commode when he lost his balance, resulting in a backward fall with head strike. He resides in a single-family home in Bulle Rock with his wife, who is his primary caregiver, and his son was present during today's visit. Upon assessment, all prescribed medications were present in the home. The patient is currently receiving daily intravenous furosemide (Lasix) via a peripheral IV in the left hand for management of volume overload until euvolemic status is achieved. On examination, the patient denied pain and shortness of breath. Respiratory assessment revealed clear lung sounds bilaterally. Mild bilateral lower extremity edema persisted, though improved. The patient ambulates with an upright walker and requires one-person assistance for safety due to generalized muscle weakness and an unsteady gait. During the visit, the patient was observed ambulating in his home office using a hiking cane instead of the recommended rolling walker; he was instructed to discontinue use of the cane, obtain an additional walker if needed, and consistently use a walker to reduce fall risk. Skin assessment revealed incontinence-associated skin breakdown to the buttocks, with no other wounds noted. The caregiver was educated on proper skin care, including liberal and frequent application of barrier cream, cleansing only soiled areas, avoiding removal of intact protective cream, and reapplying as needed, with understanding verbalized. The patient will require ongoing education regarding heart failure self-management, including adherence to a low-sodium diet, a fluid restriction of six cups per day, and proper technique for obtaining and recording daily weights to monitor fluid status. A home exercise program was initiated and taught with demonstration to address deconditioning, strength, and balance deficits. Exercises included straight leg raises, lower extremity abduction and adduction, long arc quadriceps, side kicks, marching in place, mini squats, and heel raises, performed for two sets of ten repetitions each. The patient tolerated the exercises without complaint and denied pain throughout the session. The plan of care focuses on continued skilled nursing for monitoring of cardiopulmonary status, edema, IV therapy, skin integrity, and patient and caregiver education, as well as therapeutic exercise and mobility training to improve strength, gait stability, and safety, reduce fall risk, and support safe management of chronic conditions within the home environment.
 Date of Order 01/19/2026 Orders Physician Face-to-Face Date: 01/15/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat due to Pressure Ulcer Of Sacral Region Stage 2 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:
 Physician Sharma, Sonia

SN Careplans

SN WK1: 1 (01/19/26-01/24/26) ,WK2: 1 (01/25/26-01/31/26) ,WK3: 1 (02/01/26-02/07/26) ,WK4: 1 (02/08/26-02/14/26) ,WK5: 1 (02/15/26-02/21/26) ,WK6: 1 (02/22/26-02/28/26) ,WK7: 1 (03/01/26-03/07/26) ,WK8: 1 (03/08/26-03/14/26) ,WK9: 1 (03/15/26-03/19/26)

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: 2. Non-agency caregiver(s) need training/supportive services to 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, 4. Multiple emergency department visits (2 or more) in the past 6 months, 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; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.
Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.
Provide education content at patient's level of health literacy.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.
Assess: Musculoskeletal status.
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

SN Goals

PATIENT-STATED GOAL: Patient states he wants to stop falling so much and be able to get out of the house more.

GOALS
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
* 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
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* 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
* 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 manage inflammatory process
* optimize mobility with active and passive range of motion exercises

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

01/19/2026

Home Health Certification and Plan of Care

Order ID: 1150/15559

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01201812	01/19/2026	From: 01/19/2026 To: 03/19/2026	21568	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Marvin Hodges 540 Temperence Hill Way, HAVRE DE GRACE, MD 21078- 667-201-4002	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

; 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: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, weight gain > 2lb/24 h OR 5lb/1 wk, dependent edema, frequent urination, M1610 - Urinary Incontinence, limited endurance, muscle weakness, limited strength, limited range of motion, daytime fatigue, balance deficit, Pain Interference with ADLs, Pain Effect on Sleep, obesity, rough/scaly/cracked skin, discolored patches of skin, swell/redness surround. skin, skin breakdown r/t incontinence

PROCEDURES: cough/deep breathing exercises, physician-ordered wound care: Apply barrier cream to buttocks every brief change and when soiled., monitor intake & output, 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 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * how to manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, related medic, * how to keep journal of food and fluid intake healthy meal plan tips exercise program nutritional knowledge, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

* fluid and diet intake to promote healing
* prevent constipation
* home safety
* recalls related medic

patient/caregiver recalls
* how to keep journal of food and fluid intake
* healthy meal plan tips
* exercise program
* nutritional knowledge
* recalls related medication(s) purpose, schedule

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

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (01/19/26-01/24/26) ,WK2: 2 (01/25/26-01/31/26) ,WK3: 2 (02/01/26-02/07/26) ,WK4: 2 (02/08/26-02/14/26) ,WK5: 1 (02/15/26-02/21/26) ,WK6: 1 (02/22/26-02/28/26) ,WK7: 1 (03/01/26-03/07/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, GG0170G1 - Car Transfer, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing

PROCEDURES: Medication Review: The medication was reviewed with the patient , Home exercises : SLR, LONG ARC , LE ABD/ADD, MINI SQUATS AND HEEL RAISES --10X2 REPS , cough/deep breathing exercises, incentive spirometer, equipment training, 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 medicatio, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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, 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To get stronger and walk better

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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 medicatio

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

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

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 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	01/19/2026