Home Health Certification and Plan of Care

Order ID: 1150/15828

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
071102327	01/24/2026	From: 01/24/2026 To: 03/24/2026	21787	217058

6. Patient's Name and Address

Thomas Goggins
3510 Courtleigh Drive,
WINDSOR MILL, MD 21244-
410-922-5305

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 08/20/1939 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I69.322	Dysarthria following cerebral infarction	01/24/26

13. ICD	Other Pertinent Diagnoses	Date
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	01/24/26
N18.6	End stage renal disease	01/24/26
Z99.2	Dependence on renal dialysis	01/24/26
H90.3	Sensorineural hearing loss bilateral	01/24/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	01/24/26
E78.00	Pure hypercholesterolemia unspecified	01/24/26
N25.81	Secondary hyperparathyroidism of renal origin	01/24/26
I70.0	Atherosclerosis of aorta	01/24/26
D57.3	Sickle-cell trait	01/24/26
Z79.82	Long term (current) use of aspirin	01/24/26
Z91.81	History of falling	01/24/26
Z96.652	Presence of left artificial knee joint	01/24/26

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

Amilodipine - Amlodipine Besylate 5 mg 1tablet by mouth once a day Take 1 tablet by mouth daily
Atorvastatin - Atorvastatin Calcium 40 mg by mouth once a day
8-Hour Bayer - Aspirin 81 mg 1tablet by mouth once a day Chew and swallow 1 tablet by mouth daily
Allopurinal - Allopurinol 100 mg 1tablet by mouth at bedtime Take 1 tablet by mouth daily
Gabapentin - Gabapentin 300 mg 1capsule by mouth at bedtime Take 1 capsule by mouth daily at bedtime
Furosemide - Furosemide 80 mg 1tablet by mouth twice a day Take 1 tablet by mouth twice a day on non dialysis days
Dialyvite multivitamin supplement for dialysis patients 100mg= 1 tab by mouth in the morning 1 tab daily for vitamin repletion while on HD
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 3000 units by mouth once a day 3000 units daily for vitamin D repletion
Colace - Docusate Sodium 100mg 1 tab by mouth once a day 1 tab daily for constipation

14. DME and Supplies:

cane, 4 wheeled walker

15. Safety Measures:

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

16. Nutrition:

renal diet

17. Allergies:

lisinopril

18.A. Functional Limitations

Endurance, Speech, , Ambulation, Hearing

18.B. Activities Permitted

Up As Tolerated, Exercises Prescribed, Transfer bed/Chair

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, 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, 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

family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Dysarthria Following Cerebral Infarction, 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 86-year-old male, retired Army paratrooper and veteran, referred by his primary care provider for skilled nursing, physical therapy, occupational therapy, home health aide, and social work services. The patient resides in a single-family, bilevel home with his son, who is away most of the day and returns primarily to shower and do laundry. The home environment includes multiple staircases, with approximately eight steps to the basement and four steps to the second level where the patient's bedroom is located. The patient completes his own laundry but reports difficulty carrying items up and down the stairs due to mobility limitations. He has experienced multiple falls, with the most recent occurring last Sunday, which he attributes to limited left knee mobility following a total knee arthroplasty performed 12 years ago. Despite multiple surgeries, the patient did not regain full range of motion and currently uses canes throughout the home for ambulation. The patient's past medical history is significant for cerebrovascular accident with unspecified deficits and residual dysarthria, chronic kidney disease/end-stage renal disease on hemodialysis three times weekly (Monday, Wednesday, Friday), hypertension, coronary artery disease, hyperlipidemia, type 2 diabetes mellitus with nephropathy, hyperparathyroidism, atherosclerosis, sickle cell trait, memory loss, recurrent falls, unsteady gait, and bilateral sensorineural hearing loss. The patient has a left upper extremity arteriovenous fistula in the upper bicep region and continues to drive himself to dialysis, which is located approximately five minutes from his home. The patient reports persistent hearing impairment despite the use of three sets of VA-issued hearing aids and has a scheduled hearing evaluation in April, with plans for follow-up with ENT. He previously participated in speech therapy but reports limited opportunity to practice due to spending much of his time alone. The patient also reports coughing when swallowing, warranting continued monitoring. Cognitively, the patient demonstrates some memory deficits but is able to recall recent events. He has been referred to a memory care clinic and may require assistance with appointment scheduling. Skilled nursing provided medication education, with medications written out and posted on the refrigerator for reference, and completed the patient's calendar to reflect upcoming clinician <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> to support adherence and orientation. Nursing also recommended that the patient contact the VA regarding eligibility for a free aide following completion of home health services to ensure continuity of support. Additionally, the patient expressed interest in contacting the VA to explore installation of a stair chair lift, potentially with assistance from a known acquaintance. Physical therapy evaluation revealed chronic, non-progressive lower extremity impairments, including left knee flexion limited to approximately 90 degrees, gross bilateral lower extremity strength of 4/5, and long-standing balance deficits related to orthopedic history and sensory impairments rather than acute decline. The patient ambulates greater than 150 feet within the home using a cane at modified independence, with no noted deviation from baseline function. Bed mobility and transfers are performed independently to modified independently. Given the patient's stable functional status, absence of measurable decline, lack of skilled rehabilitation potential, and no acute change from baseline, skilled home health physical therapy services are not indicated at this time. Occupational therapy <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> identified bilateral upper extremity weakness with muscle strength measured at 3+/5 and bilateral grip strength at 3/5,

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 01/24/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Gin Khai
7670 Quarterfield Rd
Glen Burnie, MD 21061
PHONE: 410-508-7650 FAX: NPI: 1003443078

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 : 01/22/2026

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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contributing to difficulty with fine motor coordination and grasp. The patient reports challenges with dressing tasks, particularly fastening, buttoning, and zipping. He is modified independent for bathing in a step-in shower and independent with toilet and shower transfers. Occupational therapy services are indicated to address upper extremity strength, coordination, and compensatory strategies to improve safety and independence with activities of daily living. A home health aide referral was placed to assist with patient care needs and to provide education to the patient's son regarding home safety and assistance with activities of daily living. Social work services were also ordered to assist with access to community and VA resources, coordination of care, and support with appointment scheduling and long-term planning. The overall plan of care focuses on maintaining patient safety, reducing fall risk, supporting independence with ADLs, ensuring medication adherence, and facilitating access to appropriate resources and services.
 Date of Order 01/24/2026 Orders Physician Face-to-Face Date: 01/22/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat HHA SW due to Dysarthria Following Cerebral Infarction 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 Khai, Gin

SN Careplans

SN WK1: 1 (01/24/26-01/24/26) ,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)

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, 5. Decline in mental, emotional, or behavioral status 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; 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.

; 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: , M1745 - Behavioral Issues, M2020 - Oral Med Management, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, cough/gag/pain chew/swallow, poor muscle tone, limited range of motion, muscle weakness, limited strength, limited endurance, B0200 - Hearing Deficit, B1000 - Vision Deficit, daytime fatigue, balance deficit, impaired speech, #1 - Observable Surgical Wound - Other - Left upper arm -

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - Left upper arm -, physician-ordered wound care, wound vacuum, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired, coordinate/arrange home modifications for hearing impaired, i.e. alarms, monitor dialysis schedule

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet

SN Goals

PATIENT-STATED GOAL: Patient states he wants to continue to be as independent as possible in his home but safely so he does not continue to fall all the time.

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 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 is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* 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

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/24/2026

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changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medicatio, * 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, * 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, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, 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, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK2: 1 (01/25/26-01/31/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 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, Car Transfer - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: PT evaluation only

GOALS
Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

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

Car Transfer - 05. Setup or clean-up assistance

OT Careplans

OT 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)

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 , Therapeutic exercise, Fine motor coordination , Patient/caregiver recalls related purpose and schedule of medications: Medication review , 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 medicatio, 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, Eating - 06. Independent, Upper Body Dressing - 06. Independent, Patient will demonstrate improved bilateral upper extremity muscle strength from 3+/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks , Patient will demonstrate improved bilateral upper grip strength from 3/5 mmt to 4/5 mmt to improve ADLs and transfers within 6 wks

OT Goals

PATIENT-STATED GOAL: Wants to be able button and fasten

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 medicatio

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Patient will demonstrate improved bilateral upper extremity muscle strength from 3+/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

Patient will demonstrate improved bilateral upper grip strength from 3/5 mmt to 4/5 mmt to improve ADLs and transfers within 6 wks

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/24/2026