Home Health Certification and Plan of Care

Order ID: 1150/16054

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
19163373	02/05/2026	From: 02/05/2026 To: 04/05/2026	22173	217058

6. Patient's Name and Address
William Bishop
10752 Frederick Rd,
ELLICOTT CITY, MD 21042-
410-491-8900

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 09/19/1929 **9.Sex** Male

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

Ventolin Hfa - Albuterol Sulfate 0 108 (90 BASE) mcg/act aerosol solution inhalant as necessary Take 1 puff by inhalation every 6 hours as needed for Wheezing.
Asa 325Mg - Aspirin 325mg by mouth once a day

11. ICD	Principal Diagnosis	Date
I96.	Gangrene not elsewhere classified	02/05/26

13. ICD	Other Pertinent Diagnoses	Date
I70.201	Unsp athscl native arteries of extremities right leg	02/05/26
L89.613	Pressure ulcer of right heel stage 3	02/05/26
C4A.61	Merkel cell carcinoma of right upper limb inc shoulder	02/05/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	02/05/26
I71.40	Abdominal aortic aneurysm without rupture unspecified	02/05/26
J45.909	Unspecified asthma uncomplicated	02/05/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	02/05/26
Z46.6	Encounter for fitting and adjustment of urinary device	02/05/26
Z85.828	Personal history of other malignant neoplasm of skin	02/05/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	02/05/26
Z86.711	Personal history of pulmonary embolism	02/05/26

14. DME and Supplies:
wound care supplies

15. Safety Measures:
bathroom safety, , , , Wound care interventions

16. Nutrition:
regular

17. Allergies:
no known allergies

18.A. Functional Limitations
None of the above

18.B. Activities Permitted
No Restrictions, Up As Tolerated

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: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

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 Gangrene Not Elsewhere Classified, 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 96-year-old male admitted to home health services following a recent acute care hospitalization for necrotic changes and gangrene of the left fifth toe. His past medical history is significant for anemia, asthma, coronary artery disease (CAD), pulmonary embolism, cerebrovascular accident (stroke), prior small bowel resection, abdominal aortic aneurysm, and a history of carcinoma, including basal cell carcinoma. Skilled nursing services were initiated for wound care management, with physical therapy (PT) and occupational therapy (OT) evaluations ordered. On assessment, the patient was alert and oriented to person, place, time, and situation, and he denied pain at the time of evaluation. Vital signs were obtained and documented. Respiratory assessment revealed audible expiratory wheezing; however, the patient denied shortness of breath, dizziness, nausea, or vomiting. A palpable abdominal hernia was noted on examination. The patient has an indwelling Foley catheter, which is reportedly changed monthly at Kaiser. Wound assessment revealed dressed wounds to the left shin and right ankle, reportedly changed every other day, most recently the day prior to assessment. Dressings were dry and intact, with a small amount of dry drainage noted on the right ankle dressing. The left foot examination demonstrated a wound on the middle toe without drainage or odor, and complete necrosis of the left fifth toe consistent with recent gangrenous changes. The left toes were cleansed, Betadine was applied, and a dry sterile dressing was placed. The foot was wrapped and secured with a stockinette. Photographic documentation was obtained per protocol. The patient was formally admitted to home health for ongoing skilled nursing wound care management and monitoring for signs of infection or further tissue compromise. A physical therapy evaluation was completed only. The patient declined initiation of skilled PT services at this time, stating he does not feel therapy is necessary. He demonstrated appropriate insight and decision-making capacity regarding this refusal. Based on chart review, current functional presentation, and patient preference, no skilled PT services were initiated. The patient was educated that therapy services may be reconsidered in the future should his functional status decline or new mobility concerns arise. Occupational therapy evaluation revealed that the patient resides alone in a single-family home. He is ambulatory without an assistive device and reports "furniture surfing" for support despite owning a rolling walker, which he does not use. He requires standby assistance for sit-to-stand and toilet transfers and is modified independent with dressing, bathing, and toileting tasks. Bilateral upper extremity muscle strength was assessed at 5/5 on manual muscle testing. Despite education regarding the potential benefits of OT services to address safety and fall prevention, the patient declined further occupational therapy intervention at this time. The plan of care includes continued skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> for wound management, ongoing assessment of cardiopulmonary status given his history of CAD and asthma with observed wheezing, monitoring of Foley catheter status, reinforcement of infection prevention strategies, and safety education. The patient was instructed to report increased pain, drainage, redness, swelling, foul odor, fever, shortness of breath, or changes in functional status promptly. Interdisciplinary communication will continue, and therapy services may be reinitiated if the patient's needs change.
 Date of Order 02/05/2026 Orders <span

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 02/05/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Apostolos Paspaltzis
7141 Security Blvd
Baltimore, MD 21207
PHONE: 4436636000 FAX: NPI: 1861092025

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 : 01/30/2026

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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style="font-size: 14px;">Physician Face-to-Face Date: 01/30/2026 Clinical Condition Requiring home Care per Certifying Physician: SN-disease management   PT-eval & treat   OT-eval & treat HHA due to Gangrene Not Elsewhere Classified 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 Paspaltzis, Apostolos

SN Careplans

SN WK1: 1 (02/05/26-02/07/26) ,WK2: 3 (02/08/26-02/14/26) ,WK3: 3 (02/15/26-02/21/26) ,WK4: 3 (02/22/26-02/28/26)

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: 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; 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:Do not resuscitate (DNR) orders

PROBLEMS IDENTIFIED ON ASSESSMENT: D0700 - Social Isolation, M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, M1033 - Exhaustion, M1400 - Dyspnea, delayed capillary refill, wheezing, lung sounds not clear, M1610 - Urinary Catheter, #2 - Open Wound - Other - Left pinky toe - Necrotic tissue noted, #1 - Open Wound - Other - Left middle toe - , open sores/lesions, pallor, discolored patches of skin, itchy skin

PROCEDURES: physician-ordered wound care: #2 - Open Wound - Other - Left pinky toe - Necrotic tissue noted, physician-ordered wound care: #1 - Open Wound - Other - Left middle toe -: Clean, apply betadine and wrap, cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments

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 achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * urinary catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, related medication(s) purpose, sch, * 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, * strategies to increase socialization, related medication(s) purpose, schedule, patient's transportation needs are met, patient is adequately supervised, caregiver administers and/or packages medications

SN Goals

PATIENT-STATED GOAL: I want my wounds to heal

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
* urinary catheter management including how to flush catheter
* change and wash drainage bags
* prevent infection including proper handwashing
* positioning of catheter
* recalls related medication(s) purpose, sch

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/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

patient is adequately supervised

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	02/05/2026

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appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK2: 1 (02/08/26-02/14/26)

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: transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 03. Partial/moderate assistance, 1 - Step (curb) - 02. Substantial/maximal assistance, 12 Steps - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Car Transfer - 04. Supervision or touching assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

PT Goals

PATIENT-STATED GOAL: Evaluation only

GOALS
Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Toilet Transfer - 03. Partial/moderate assistance

1 - Step (curb) - 02. Substantial/maximal assistance

12 Steps - 02. Substantial/maximal assistance

4 Steps - 02. Substantial/maximal assistance

Car Transfer - 04. Supervision or touching assistance

Picking Up Object - 02. Substantial/maximal assistance

Walk 10 Feet - 02. Substantial/maximal assistance

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Walk 150 Feet - 02. Substantial/maximal assistance

Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

OT Careplans

OT WK2: 1 (02/08/26-02/14/26)

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

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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 1 - Step (curb) - 02. Substantial/maximal assistance, 12 Steps - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Car Transfer - 05. Setup or clean-up assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: Eval only

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

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

1 - Step (curb) - 02. Substantial/maximal assistance

12 Steps - 02. Substantial/maximal assistance

4 Steps - 02. Substantial/maximal assistance

Car Transfer - 05. Setup or clean-up assistance

Picking Up Object - 02. Substantial/maximal assistance

Walk 10 Feet - 02. Substantial/maximal assistance

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Walk 150 Feet - 02. Substantial/maximal assistance

Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/05/2026