Home Health Certification and Plan of Care

Order ID: 1150/16075

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
4YG6EJ3TE76	09/17/2025	From: 01/15/2026 To: 03/15/2026	9045	217058

6. Patient's Name and Address
John Zareva
570 Bellerive Drive,
ANNAPOLIS, MD 21409-
301-655-9931

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 04/05/1938 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
G89.29	Other chronic pain	09/17/25

13. ICD	Other Pertinent Diagnoses	Date
M25.551	Pain in right hip	09/17/25
M25.561	Pain in right knee	09/17/25
M79.605	Pain in left leg	09/17/25
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	09/17/25
I10.	Essential (primary) hypertension	09/17/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	09/17/25
E78.5	Hyperlipidemia unspecified	09/17/25
E03.9	Hypothyroidism unspecified	09/17/25
F32.A	Depression unspecified	09/17/25
I25.2	Old myocardial infarction	09/17/25
Z95.1	Presence of aortocoronary bypass graft	09/17/25
Z91.51	Personal history of suicidal behavior	09/17/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	09/17/25
Z79.82	Long term (current) use of aspirin	09/17/25

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

Metformin Hcl - Metformin Hydrochloride 500 MG, Give 1 tablet by mouth once a day Take with meals
Levothyroxine Sodium - Levothyroxine Sodium 100 MCG, Give 1 tablet by mouth in the morning
Acetaminophen - Acetaminophen 500 MG,Give 2 tablet by mouth every 4 hours
Magnesium - Simethicone 64 Mg, Give 2 tablet by mouth once a day
Cozaar - Losartan Potassium 100 MG, Give 1 tablet by mouth once a day
Amlodipine Besylate - Amlodipine Besylate 10 MG, Give 1 tablet by mouth once a day
Biotin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25 MCG (1000 UT), Give 1 tablet by mouth once a day
Cyanocobalamin - Cyanocobalamin 1000 MCG, Give 1 tablet by mouth once a day
Aspirin 81Mg - Aspirin 81 Mg, Give 1 tablet by mouth twice a day
Vascepa - Icosapent Ethyl 1 GM, Give 1 capsule by mouth twice a day
Clopidogrel - Clopidogrel 75 by mouth once a day
Medrol - Methylprednisolone 4 mg by mouth three times a day
Medrol - Methylprednisolone 4 mg by mouth three times a day
Imdur - Isosorbide Mononitrate 60 mg by mouth once a day
Carvedilol - Carvedilol 25 mg by mouth twice a day 1 tab x 2 a day
Systane Eye Drops - Normal Saline 10 ml both eyes as necessary

14. DME and Supplies:
rolling walker, walker,

15. Safety Measures:
activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Dyspnea With Minimal Exertion, Ambulation, Hearing

18.B. Activities Permitted
Exercises Prescribed, Walker, Independent at Home

19. Mental & Pyschosocial Status: COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: , SOCIAL ISOLATION: 2 independent, BEHAVIORAL ISSUES: 2 independent, HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: na, MOBILITY: na

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 Other Chronic Pain, 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 with a past medical history of myocardial infarction, coronary artery disease, hypertension, type 2 diabetes mellitus, hypothyroidism, recurrent falls, and recent hospitalization for a mechanical fall resulting in a splenic subcapsular hematoma and left eyebrow laceration. He was hospitalized for two weeks, followed by two weeks of inpatient rehabilitation, and has since transitioned to a single-level apartment in Annapolis arranged by his daughter, Kelly, who resides nearby and provides daily check-ins. The patient also receives home care services and physical therapy. He ambulates with a front-wheeled walker (FWW) and utilizes adaptive equipment such as a bath bench. Despite these supports, he reports experiencing approximately 6-7 falls in the past two months and 9-10 falls in the past year, describing his legs as "giving out" during episodes. His primary goal is to regain functional mobility and return to safe community ambulation without falls. On assessment, the patient is alert and oriented 3, ambulated to the front door to greet the clinician, and denied chest pain, dizziness, or palpitations. He endorses shortness of breath with minimal exertion, which has been ongoing for the past 3-4 months. Lung sounds are clear, bowel sounds are normoactive with a bowel movement documented this morning, urination is without complication, pedal pulses are intact, and no peripheral edema is noted. He reports numbness and tingling in the lower extremities and has cellulitis-related pain in the right leg. He is preparing for upcoming cataract surgery. Functionally, the patient demonstrates right lower extremity pain, bilateral lower extremity weakness, decreased balance, impaired transfers, unsteady gait, and reduced safety awareness. He requires supervision to minimal assistance for safe ambulation with a walker, with cues provided for proper positioning and improved step height and length. Sit-to-stand and turning movements remain challenging. Patient completed seated therapeutic exercises, including hip flexion, long arc quadriceps, hip abduction, and pillow squeezes (115 each). A home exercise program (HEP) was provided and reviewed, with instructions to perform exercises twice daily. Education was provided on safe walker use, fall prevention, and the importance of consistent walker use at all times. The patient verbalized understanding of all instructions. Given his history of frequent falls, functional decline, poor safety awareness, and high risk for further injury, the patient is considered homebound, as leaving the home requires human assistance and an assistive device. He will benefit from skilled physical therapy services to improve lower extremity strength, endurance, functional mobility, transfers, balance, and safety awareness to support independence and reduce fall risk. The plan of care includes home PT with frequency beginning September 17, 2025 (1 visit week one, 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> week two [Tues/Thu], 1 visit week six [Tues]). The patient is in agreement with the PT plan of care. Ongoing skilled services remain medically necessary to optimize safety, prevent further decline, and promote return to prior level of function.
 Date of Order 01/13/2026 Orders Physician Face-to-Face Date: 09/04/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Other Chronic Pain Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 4 -

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/13/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Alise Burke
2002 Medical Pkwy
Annapolis, MD 21401
PHONE: 4434811150 FAX: 14102240065 NPI: 1891354296

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 : 09/04/2025

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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Recertification Notes: The patient is being recertified due to complaints of tingling and burning sensations in both feet. Physician Burke, Alise

SN Careplans

SN Goals

OT Careplans

OT WK2: 1 (01/18/26-01/24/26) ,WK3: 1 (01/25/26-01/31/26)

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:

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

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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: limited range of motion, loss of appetite

PROCEDURES: work simplification/energy conservation, Medication Review: Medications 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, * how to

OT Goals

PATIENT-STATED GOAL: improve his condition and prevent falling

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/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

Shower/Bathe Self - 06. Independent

Don/Doff Footwear - 06. Independent

Medication review

Balance training

Therapeutic exercise

Toileting Hygiene - 06. Independent

Eating - 06. Independent

Lower Body Dressing - 06. Independent

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/13/2026

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Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/13/2026