Home Health Certification and Plan of Care

Order ID: 1150/16247

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
47101739900	02/11/2026	From: 02/11/2026 To: 04/11/2026	20729	217058

6. Patient's Name and Address

Joseph Hardy
520 PRINCE CHARLES AVENUE,
Odenton, MD 21113-
240-319-6954

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 07/26/1958 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
J44.9	Chronic obstructive pulmonary disease unspecified	02/11/26

13. ICD	Other Pertinent Diagnoses	Date
I11.0	Hypertensive heart disease with heart failure	02/11/26
I50.32	Chronic diastolic (congestive) heart failure	02/11/26
E11.65	Type 2 diabetes mellitus with hyperglycemia	02/11/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	02/11/26
I87.2	Venous insufficiency (chronic) (peripheral)	02/11/26
E78.5	Hyperlipidemia unspecified	02/11/26
D64.9	Anemia unspecified	02/11/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	02/11/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	02/11/26
M48.00	Spinal stenosis site unspecified	02/11/26
M47.819	Spondylosis without myelopathy or radiculopathy site unsp	02/11/26
F17.210	Nicotine dependence cigarettes uncomplicated	02/11/26
E66.2	Morbid (severe) obesity with alveolar hypoventilation	02/11/26
Z68.37	Body mass index [BMI] 37.0-37.9 adult	02/11/26
Z99.81	Dependence on supplemental oxygen	02/11/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	02/11/26
Z79.82	Long term (current) use of aspirin	02/11/26

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

Amlodipine - Amlodipine Besylate 10 mg , Tablet by mouth once a day 10 mg, Oral, 1 time daily
BLOOD PRESSURE
Oxygen - Oxygen 5 litres nasal cannula continuous SUPPLEMENT
COPD
Advair - Fluticasone Propionate: Salmeterol Xinafoate 500-50 MCG/ACT inhaler, 1 puff, inhalant every 12 hours 1 puff, EVERY 12 HOURS
COPD
Albuterol Inhaler - Albuterol 108 (90 BASE) mcg/act, 2 puffs, Inhalation, inhalant every 4 hours 2 puffs, Inhalation, every 4 hours PRN FOR SOB
COPD
Albuterol - Albuterol 0.09 mg/inh .5-2.5 (3) mg/3mL nebulizer solution , 3 mLs, Nebulization inhalant every 4 hours 3 mLs, Nebulization, every 4 hours PRN FOR SOB
COPD
Acetaminophen - Acetaminophen 500MG; 1-2 TABS by mouth as necessary AS DIRECTED
FOR PAIN
Cozaar - Losartan Potassium 100 mg 100 mg 100 mg, Tablet by mouth once a day 100 mg, Oral, 1 time daily
BLOOD PRESSURE
Lipitor - Atorvastatin Calcium eq 40 mg base eq 40 mg base 40 mg, Tablet by mouth at bedtime 40 mg, nightly
CHOLESTEROL
Coreg - Carvedilol 6.25 mg 25 mg 25MG; 1TAB by mouth twice a day
HEART/BLOODPRESSURE
Lasix - Furosemide 20 mg 40 mg 40 mg, Tablet by mouth once a day 1-2 tabs daily for leg edema FLUID PILL
Jardiance - Empagliflozin 25mg; 1/2 tab by mouth once a day CHF

14. DME and Supplies:

hand held shower, walker, oxygen supplies, bath bench, diabetic supplies, rolling walker, cane

15. Safety Measures:

diabetic precautions, ambulates with device, walker precautions, , , , ambulates with assistance, transfer with assist, sharps precautions

16. Nutrition:

fluid restriction, cardiac diet, 3GM SODIUM; 1500ML FLUID RESTRICTION

17. Allergies:

gabapentin

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Cane, Walker, Exercises Prescribed, 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: fair

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

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Chronic Obstructive Pulmonary Disease Unspecified, 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 67-year-old male with a significant past medical history including chronic obstructive pulmonary disease (COPD) with chronic respiratory failure requiring continuous supplemental oxygen (currently 5 L/min via nasal cannula; previously documented at 3.5 L/min), heart failure with preserved ejection fraction (HFpEF), peripheral artery disease (PAD), hypertension, hyperlipidemia, degenerative arthritis of the spine, spinal stenosis, neuropathic pain of the lower extremities, hypoxia, prior COPD exacerbations, and aspiration pneumonitis. He was recently readmitted to the hospital following a fall in the bathroom during which he was unable to get up and experienced severe shortness of breath; emergency medical services were activated by a friend. He was hospitalized for four days and subsequently returned home. He had also presented to the emergency department on 12/21/2025 at Saint Agnes Hospital with progressively worsening shortness of breath over three days, productive cough with brownish sputum, and significant bilateral lower extremity edema associated with an unintentional weight gain of approximately 50 pounds over the past several months. The patient reports multiple falls over the past year, including two to three falls within the last two months, attributed to lower extremity edema, weakness, impaired balance, and dyspnea on exertion. He sustained superficial leg wounds from prior falls, which are now healed. The patient lives alone in a single-level home with one step and a small ramp at the entrance. He receives assistance from a neighbor, family, and friends for activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed; however, he has expressed interest in exploring long-term care resources for additional support. Social work services have been ordered to assist with community resource coordination and long-term care planning. Occupational therapy evaluation has been ordered to assess the need for home health aide services, and physical therapy and skilled nursing services have been initiated. Skilled nursing frequency is ordered as 1 visit per week for 12 weeks, followed by 4 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> per week for 1 week, then 3 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> per week for 1 week (1W12, 4W1, 3W1). At the time of <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was alert and oriented to person, place, and time. Random fingerstick blood glucose was 170 mg/dL. He denied pain and denied shortness of breath at rest during the visit. He reports intermittent lower back pain but no pain at the time of evaluation. He uses a nebulizer as needed for episodes of increased shortness of breath. Functionally, the patient ambulates short distances within the home using a cane; he utilizes a rolling walker for increased stability and a wheelchair for longer distances or when leaving the home. He becomes short of breath

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/11/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Kenneth Villar
7670 Quarterfield Road
Glen Burnie, MD 21061
PHONE: FAX: NPI: 1235314436

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 : 02/05/2026

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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with minimal exertion. Prior to the recent fall, he was able to shower independently and dress himself, though he requires assistance with donning socks and shoes. He is able to prepare simple meals such as sandwiches and light snacks. He has not driven in approximately three years. Physical therapy evaluation reveals decreased bilateral lower extremity strength, impaired balance, unsteady gait, decreased functional mobility, difficulty negotiating steps, impaired transfer ability, poor safety awareness, and a high risk for falls. The patient demonstrates significant deconditioning and limited activity tolerance secondary to cardiopulmonary impairments. He will benefit from skilled home physical therapy to address strength deficits, improve functional mobility and transfers, enhance gait safety with appropriate assistive devices, improve balance, and increase safety awareness in order to restore maximal independence within the home environment. Without skilled intervention, the patient remains at high risk for recurrent falls, further functional decline, rehospitalization, and loss of independence. The physical therapy plan of care is scheduled to begin 02/18/2026 with a frequency of 1 visit for 1 week, 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> per week for 2 weeks (Tuesday/Thursday), followed by 1 visit per week for 3 weeks (Tuesday). The patient is in agreement with the physical therapy plan of care. Overall goals include cardiopulmonary endurance training within tolerance, fall prevention, safety education, and coordination of interdisciplinary services to support long-term independence and reduce risk of further exacerbations and hospital readmissions.
 Date of Order 02/11/2026 Orders Physician Face-to-Face Date: 02/05/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat HHA due to Chronic Obstructive Pulmonary Disease Unspecified 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 Villar, Kenneth

SN Careplans

SN WK1: 1 (02/11/26-02/14/26) ,WK2: 1 (02/15/26-02/21/26) ,WK3: 2 (02/22/26-02/28/26) ,WK4: 2 (03/01/26-03/07/26) ,WK5: 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: 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) 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; 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, Home Safety, Home Safety, M1033 - Exhaustion, M1400 - Dyspnea, lung sounds not clear, dependent edema, abnormal BS < 70/140 > mg/dL, limited strength, limited endurance, balance deficit, obesity, rough/scaly/cracked skin

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor: PATIENT OBTAIN DAILY FINGERSTICK

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, * 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 living environment has safe floor coverings, patient's living environment is clean/uncluttered, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: TO GET BETTER

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
* 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 living environment has safe floor coverings

patient's living environment is clean/uncluttered

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 8 (02/11/26-02/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, 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: cough/deep breathing exercises, home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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

PT Goals

PATIENT-STATED GOAL: I would like to be able to walk better and to get stronger

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

1 - Step (curb) - 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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/11/2026

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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

OT Careplans

OT WK1: 1 (02/11/26-02/14/26) ,WK2: 1 (02/15/26-02/21/26) ,WK3: 1 (02/22/26-02/28/26) ,WK4: 1 (03/01/26-03/07/26) ,WK5: 1 (03/08/26-03/14/26) ,WK6: 1 (03/15/26-03/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: , Pain Effect on Sleep, 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: Therapeutic exercise , Balance training , Medication review , Endurance training , cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation, gait training on uneven surfaces, 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, * 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: to improve funcationality

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

1 - Step (curb) - 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

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 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	02/11/2026