Home Health Certification and Plan of Care

Order ID: 1150/16422

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
36294046	02/19/2026	From: 02/19/2026 To: 04/19/2026	22703	217058

6. Patient's Name and Address

John Brown
3904 DUDLEY AVE,
BALTIMORE, MD 21213-
443-690-4583

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 02/12/1950 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
J69.0	Pneumonitis due to inhalation of food and vomit	02/19/26

13. ICD	Other Pertinent Diagnoses	Date
F01.50	Vascular dementia unsp severity without beh/psych/mood/anx	02/19/26
B20.	Human immunodeficiency virus [HIV] disease	02/19/26
I35.1	Nonrheumatic aortic (valve) insufficiency	02/19/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	02/19/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	02/19/26
N18.30	Chronic kidney disease stage 3 unspecified	02/19/26
E78.5	Hyperlipidemia unspecified	02/19/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	02/19/26
N52.9	Male erectile dysfunction unspecified	02/19/26
K21.9	Gastro-esophageal reflux disease without esophagitis	02/19/26
K58.9	Irritable bowel syndrome without diarrhea	02/19/26
F10.90	Alcohol use unspecified uncomplicated	02/19/26
Z79.82	Long term (current) use of aspirin	02/19/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	02/19/26
Z87.440	Personal history of urinary (tract) infections	02/19/26
Z87.891	Personal history of nicotine dependence	02/19/26

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

Losartan Potassium - Losartan Potassium 100 mg 100 mg / 1 Tablet by mouth once a day Commonly known as: COZAAR
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg 0.4 mg / 1 Capsule by mouth in the evening Commonly known as: FLOMAX
Amlodipine - Amlodipine Besylate 5 mg / 1 Tablet by mouth once a day Commonly known as: NORVASC
BLOOD PRESSURE
Biktarvy 50-200-25 MG / 1 Tablet by mouth daily Generic drug: bictegravir-emtricitabine-tenofovir alafenamide. Please give at least 2 hours before or 6 hours after any supplements
Atorvastatin - Atorvastatin Calcium 80 mg / 1 Tablet by mouth once a day Commonly known as: LIPITOR
CHOLESTEROL

14. DME and Supplies:

cane

15. Safety Measures:

diabetic precautions, , supervision at all times, activity supervision

16. Nutrition:

diabetic, cardiac diet, ,

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 3. During the day and evening, but not constantly, 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!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, 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: 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

Homebound status: Due to diagnosis of Pneumonitis Due To Inhalation Of Food And Vomit , 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 76-year-old individual recently hospitalized following a syncopal episode and subsequently diagnosed with aspiration pneumonia. Past medical history is significant for vascular dementia, HIV/AIDS, aortic valve regurgitation (insufficiency), hypertension, hyperlipidemia, prediabetes/diabetes mellitus, chronic kidney disease stage III, prior stroke/transient ischemic attack (TIA), irritable bowel syndrome, and recurrent urinary tract infections. The patient resides in a townhouse with her daughter, who works outside the home but provides assistance with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The home environment includes five steps with a railing to enter and a second-floor bedroom and bathroom accessible via 14 steps with a railing. The patient is considered homebound due to the significant effort required to leave the home and impaired balance, as evidenced by a Tinetti score of 16/28, indicating a high fall risk. On <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, though forgetful consistent with her history of vascular dementia. She denied pain but reported shortness of breath with moderate exertion. Lung sounds were diminished in the bilateral lower lobes. She reported a good appetite, with last bowel movement occurring today. Poor dentition was noted. The patient ambulates approximately 30 feet indoors without an assistive device but requires supervision; a single-point cane is available in the home for safety. She is able to negotiate 14 interior stairs with a railing and supervision. Bed mobility is independent. Transfers to bed, chair, and toilet require supervision. Outdoor mobility and car transfers were not assessed during this visit. Skilled nursing services have been initiated with a frequency of 1 visit per week for 12 weeks, then 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> per week for 1 week, followed by 1 visit per week for 3 weeks. Physical therapy and occupational therapy evaluations have been ordered. The patient declined home health aide services. A follow-up appointment with the primary care provider is scheduled for Friday. Medications were reviewed with the daughter during this visit, and reconciliation will be completed at the next skilled nursing visit. Skilled nursing education was initiated regarding vascular dementia, including disease progression, safety considerations, and caregiver support strategies; the daughter verbalized understanding. Physical therapy <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> indicates decreased strength, balance, and endurance impacting functional mobility and safety. The patient tolerated 10 repetitions each of supine therapeutic exercises including hip flexion, bridging, hooklying rotation, straight leg raises, hip abduction, knee extension, and ankle pumps. She would benefit from continued home-based therapy to improve strength, balance, and functional mobility in order to return to her prior level of function and maximize independence. Occupational therapy evaluation reveals decreased standing balance, standing tolerance, bilateral upper extremity strength, and overall activity tolerance, resulting in reduced independence with self-care tasks, functional transfers, and functional

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/19/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Linda Ataifo
815 E. Pratt St
Baltimore, MD 21202
PHONE: 4106375700 FAX: NPI: 1609371905

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 : 02/14/2026

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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ambulation. Prior to hospitalization, the patient was reportedly independent with basic self-care, functional transfers, and ambulation using a single-point cane, with her daughter assisting primarily with IADLs. Skilled occupational therapy services are recommended to address current deficits and facilitate a safe return to prior level of function. The interdisciplinary plan of care focuses on cardiopulmonary monitoring, medication management, fall prevention, strengthening, endurance training, and caregiver education to promote safety and reduce risk of rehospitalization.
 Date of Order 02/19/2026 Orders Physician Face-to-Face Date: 02/14/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management PT-eval & treat OT-eval & treat HHA due to Pneumonitis Due To Inhalation Of Food And Vomit 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 Ataifo, Linda

SN Careplans

SN WK1: 1 (02/19/26-02/21/26) ,WK2: 2 (02/22/26-02/28/26) ,WK3: 2 (03/01/26-03/07/26) ,WK5: 1 (03/15/26-03/21/26) ,WK7: 1 (03/29/26-04/04/26)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 5. Decline in mental, emotional, or behavioral status in the past 3 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

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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, lung sounds not clear, limited strength, limited endurance, balance deficit, rough/scaly/cracked skin

PROCEDURES: 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, * 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, * 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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: TO FEEL 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
* 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
* 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

meal preparation is available to patient for all meals

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

02/19/2026

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PT WK1: 1 (02/19/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK5: 1 (03/15/26-03/21/26) ,WK6: 1 (03/22/26-03/28/26) ,WK7: 1 (03/29/26-04/04/26)

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: Home exercise program : Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps , equipment training, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 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 - 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

PATIENT-STATED GOAL: To get stronger in my left leg and walk like normal

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

Shower/Bathe Self - 05. Setup or clean-up assistance

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 - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Toileting Hygiene - 06. Independent

Upper Body Dressing - 06. Independent

OT Careplans

OT WK2: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK5: 1 (03/15/26-03/21/26) ,WK6: 1 (03/22/26-03/28/26) ,WK7: 1 (03/29/26-04/04/26)

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

PROCEDURES: therapeutic exercises, equipment training, work simplification/energy conservation, transfers training, assist with bathing, assist with transferring, assist with lower body dressing, assist with upper body dressing

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, 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

OT Goals

PATIENT-STATED GOAL: Walk better

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 medication(s) purpose, schedule

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Toileting Hygiene - 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	02/19/2026