Home Health Certification and Plan of Care

Order ID: 1150/16453

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
041081796	02/20/2026	From: 02/20/2026 To: 04/20/2026	22811	217058

6. Patient's Name and Address

Everett Orr
511 Franklin Avenue,
ESSEX, MD 21221-
410-686-5458

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 01/03/1938 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	02/20/26

13. ICD	Other Pertinent Diagnoses	Date
I95.1	Orthostatic hypotension	02/20/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	02/20/26
I50.22	Chronic systolic (congestive) heart failure	02/20/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	02/20/26
N18.30	Chronic kidney disease stage 3 unspecified	02/20/26
D53.9	Nutritional anemia unspecified	02/20/26
E03.9	Hypothyroidism unspecified	02/20/26
E78.5	Hyperlipidemia unspecified	02/20/26
I48.91	Unspecified atrial fibrillation	02/20/26
N40.1	Benign prostatic hyperplasia with lower urinary tract symp	02/20/26
R33.8	Other retention of urine	02/20/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	02/20/26
Z79.01	Long term (current) use of anticoagulants	02/20/26
Z79.4	Long term (current) use of insulin	02/20/26
Z79.890	Hormone replacement therapy	02/20/26
Z79.82	Long term (current) use of aspirin	02/20/26
Z95.1	Presence of aortocoronary bypass graft	02/20/26
Z95.5	Presence of coronary angioplasty implant and graft	02/20/26
Z96.641	Presence of right artificial hip joint	02/20/26
Z91.81	History of falling	02/20/26

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

Tylenol - Acetaminophen 0 325 mg / 1 Tablet by mouth every 6 hours Give 2 tablet as needed for Pain Do not exceed more than 3 grams per day from all sources
Torsemide - Torsemide 20 mg 20 mg / 1 Tablet by mouth once a day for CHF
Metoprolol Tartrate - Metoprolol Tartrate 0 12.5 mg / 1 Tablet by mouth every 12 hours for HTN Hold med for SBP <110 or HR <50
MULTIVITAMINS 0 0 1 Tablet mouth one time a day for supplement
Levothyroxine Sodium - Levothyroxine Sodium 0 112 mcg / 1 Tablet by mouth in the morning for Hypothyroidism
Insulin Glargine Solution 0 100 UNIT/ML subcutaneous at bedtime Inject 40 unit for diabetes
Insta-glucose single tube dose 0 15 gram by mouth once a day as needed for hypoglycemic episode Give 15 grams as needed for bloodsugar less than 70 as a single dose if patient is able to tolerate by mouth. Recheck blood sugar after 15 minutes and notify provider.
Greers Goo Cream 0 - topical as necessary Apply to Sacrum every shift for Redness
Greer (Nystatin + Zinc Oxide) 0 - topical as necessary Apply to bilateral buttock every shift for resness cleanse redness area to bilateral buttock with NS , apply greer cream , cover with form dressing very shift for protection
Aspirin 81Mg - Aspirin 0 / 1 Tablet by mouth once a day for CAD
Atorvastatin Calcium - Atorvastatin Calcium 0 80 mg / 1 Tablet by mouth at bedtime for HLD
DABIGATRAN ETEXILATE 0 150 mg / 1 Capsule mouth twice a day for A Fib
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 0 Delayed Release 324 (65 Fe) mg / 1 Tablet by mouth once a day every 48 hours for Anemia
Fludrocortisone Acetate - Fludrocortisone Acetate 0.1 mg 0.1 mg / 1 Tablet by mouth once a day for Orthostatic hypotension
Glycolax - Polyethylene Glycol 3350 0 17 g by mouth once a day for constipation Mix well in a full glass (120-240 ml or 4 - 8 oz) of water, juice, soda, coffee or tea prior to administration

14. DME and Supplies:

wheelchair, diabetic supplies, bath bench, walker, commode

15. Safety Measures:

bathroom safety, wheelchair precautions, cardiac precautions, , , diabetic precautions, , activity supervision

16. Nutrition:

cardiac diet, diabetic

17. Allergies:

ACE Inhibitors

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

No Restrictions

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: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., 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
family/caregiver will be responsible for managing treatment

Homebound status:

Due to diagnosis of Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris, 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 88-year-old male with a past medical history significant for hypertension, type 2 diabetes mellitus, hypothyroidism, orthostatic hypotension, congestive heart failure, chronic kidney disease, and a history of recurrent falls. He was recently hospitalized following a fall, which he attributes to orthostatic hypotension potentially exacerbated by torsemide use. He reports that torsemide lowered his blood pressure and contributed to the fall, resulting in subsequent hospitalization and transfer to a skilled nursing facility for rehabilitation. The patient states that he has independently placed his torsemide on hold due to concerns regarding hypotension. He was advised to schedule a prompt follow-up appointment with his primary care provider to review and reconcile his medications to ensure safe management of his blood pressure, heart failure, and renal status. Medication review and comprehensive physical assessment were completed during this visit. Vital signs were within normal limits, and respirations were even and unlabored. The patient is alert and oriented to person, place, time, and situation, though he is hard of hearing despite use of a hearing aid. The patient resides in a single-family home with his wife and granddaughter and utilizes an outdoor lift to assist with transfers from the car into the home. Prior to hospitalization, he was independent with basic activities of daily living, functional transfers, ambulation, instrumental activities of daily living, and driving. Currently, he presents with generalized weakness, dyspnea on exertion, decreased standing balance and tolerance, reduced activity tolerance, bilateral upper extremity weakness, and an unsteady gait, all contributing to a decline in functional mobility and self-care performance. During the visit, therapeutic exercises were initiated to improve lower extremity strength and endurance, including straight leg raises and lower extremity abduction/adduction in supine position, long arc quadriceps exercises in sitting, and marching in standing, performed for 10 repetitions x 2 sets each. His walker was adjusted to the appropriate height to promote proper posture and safety during ambulation. Skin

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Oluwakemi Ajide
4920 Campbell Blvd
Baltimore, MD 21236
PHONE: 410-933-7600 FAX: 410-933-7666 NPI: 1184919151

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 : 02/13/2026

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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assessment revealed warm, intact skin overall; however, there is chronic redness and excoriation noted to the buttocks, an issue the patient reports has persisted for many years. His spouse currently applies petroleum jelly for skin protection. Education was provided on pressure injury prevention, including use of a pressure-relieving foam cushion for his recliner and implementation of repositioning at least every two hours while sitting or lying in bed to offload pressure areas. Additional teaching was provided regarding medication adherence, the importance of routine blood pressure monitoring, fall prevention strategies, and energy conservation techniques to address dyspnea on exertion. Given the patient's recent fall, multiple comorbidities, impaired balance, weakness, decreased endurance, and decline from prior level of function, skilled physical and occupational therapy services are medically necessary to address deficits in strength, balance, functional mobility, transfer safety, and self-care performance. The plan of care includes progressive therapeutic exercise, gait and balance training, endurance training, upper extremity strengthening, safety training with assistive devices, medication management reinforcement, and ongoing patient and caregiver education. The overall goal is to safely restore the patient to his prior level of independence, reduce fall risk, improve functional capacity, and prevent rehospitalization.
 Date of Order 02/20/2026 Orders Physician Face-to-Face Date: 02/13/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat, HHA due to Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris 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 Ajide , Oluwakemi

SN Careplans

SN WK1: 1 (02/20/26-02/21/26) ,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)

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: 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, limited strength, balance deficit, B0200 - Hearing Deficit

PROCEDURES: cough/deep breathing exercises, glucose testing via monitor

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, * 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/C O2 alarms, related medication(s) purpose, schedule, patient self-administers

SN Goals

PATIENT-STATED GOAL: To be independent again

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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/20/2026

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medications as prescribed, related medication(s) purpose, schedule

PT Careplans

PT WK2: 1 (02/22/26-02/28/26) ,WK3: 2 (03/01/26-03/07/26) ,WK4: 2 (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, 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, incentive spirometer, home exercise program: slr, le abd/add, long arc , marching and eel/toe raises --10x2 reps, gait training/stair 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 medication(s) purpose, schedule

PT Goals

PATIENT-STATED GOAL: To get stronger and walk 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 medication(s) purpose, schedule

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)

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: Medication Review : Medication reviewed with patient and caregiver with all medications in the home. , gait training/stair training, transfers training, transfers training, assist with bathing, assist with lower 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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching 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, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Walk better

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/20/2026