Home Health Certification and Plan of Care

Order ID: 1150/16472

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
9RJ8G02VE39	02/21/2026	From: 02/21/2026 To: 04/21/2026	22639	217058

6. Patient's Name and Address

Kevin Blake
15 S Fulton Ave,
BALTIMORE, MD 21223-
443-961-1260

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 05/25/1956 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
E11.9	Type 2 diabetes mellitus without complications	02/21/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	02/21/26
M17.11	Unilateral primary osteoarthritis right knee	02/21/26
K25.1	Acute gastric ulcer with perforation	02/21/26
M10.09	Idiopathic gout multiple sites	02/21/26
G89.29	Other chronic pain	02/21/26
D64.9	Anemia unspecified	02/21/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	02/21/26
Z87.01	Personal history of pneumonia (recurrent)	02/21/26
Z91.81	History of falling	02/21/26

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

Azithromycin - Azithromycin 250 mg 250mg; 2 tabs by mouth once a day upper respiratory infection
x3 days
Voltaren - Diclofenac Sodium 1 perc 1 perc - topical twice a day Apply to R knee for R knee pain apply 4 g to R knee BID
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) mg / 1 Tablet by mouth once a day for supplementation
Lidocaine Patch - Lidocaine 5%; 1 patch topical once a day Apply to right knee for pain and remove per schedule
Lisinopril - Lisinopril 10 mg 10 mg / 1 Tablet by mouth once a day for hypertension Hold for SBP less than 110 or HR less than 60
MELATONIN 5 mg / 1 Tablet by mouth once a day every 24 hours as needed for sleep at bedtime
Metformin Hcl - Metformin Hydrochloride 500 mg / 1 Tablet by mouth in the morning for DIABETES MELLITUS
Multiple Vitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 Tablet by mouth once a day for nutrition support due to weight-loss
PANTOPRAZOLE 40 mg 40 mg / 1 Tablet by mouth in the morning for Gastric ulcer with perforation
Pravastatin - Pravastatin Sodium 20 mg / 1 Tablet by mouth in the evening for hyperlipidemia
Cyanocobalamin - Cyanocobalamin 1000 mcg / 1 Tablet by mouth once a day for low vitamin B12
Thiamine Hydrochloride - Thiamine Hydrochloride 100 mg / 1 Tablet by mouth once a day for supplement
Tylenol - Acetaminophen 325 mg / 2 Tablets by mouth every 6 hours Give 2 tablet as needed for PAIN
Albuterol Inhaler - Albuterol 108 (90 base); 1 puff inhalant every 6 hours as needed for sob/wheezing
Tizanidine Hydrochloride - Tizanidine Hydrochloride eq 2 mg base 2mg; 1 tab by mouth every 8 hours as needed for muscle spasms

14. DME and Supplies:

grab bars

15. Safety Measures:

standard precautions, fall precautions, diabetic precautions, medication safety, activity supervision, sharps precautions

16. Nutrition:

diabetic

17. Allergies:

penicllin

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 1. In new or complex situations only, 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, 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

another facility/provider will be responsible for managing treatment

Homebound status: Due to diagnosis of Type 2 diabetes mellitus without complications, 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 69-year-old male recently discharged from a treatment facility following hospitalization after a fall in the street related to alcohol use, during which he developed an acute gastric ulcer. According to facility staff, he previously left the hospital against medical advice and was later found after passing out. His past medical history includes homelessness, alcohol use disorder, gastric perforation, gout, hypertension, and diabetes mellitus. Blood glucose is monitored every other day, with the last fingerstick reading of 77. He is alert and oriented to person and place (2) with newly noted cognitive deficits since returning to the facility. He reports bilateral knee discomfort, denies shortness of breath, endorses a fair appetite, and is unable to recall his last bowel movement. Skilled nursing reviewed medications with the facility nurse, who manages all medications. The patient requires assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. He resides in a halfway house with five steps to enter and a third-floor bedroom and bathroom requiring navigation of 28 steps with a railing. He ambulates 40 feet without an assistive device under close supervision, completes stairs with supervision and cueing for technique, and transfers with supervision. Slow ambulation was observed, and although he previously used a cane, he does not currently have an assistive device. Outside mobility and car transfers were not assessed. The patient is considered homebound due to the significant effort required to leave home, as evidenced by a Tinetti score of 16/28. He tolerated 10 repetitions of therapeutic exercises, including hip flexion, bridging, hooklying rotation, straight leg raises, hip abduction, knee extension, and ankle pumps. He would benefit from continued home therapy to improve strength and maximize independence.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 02/21/2026
 Order<o:p></o:p> Physician Face-to-Face Date: 01/23/2026
 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat DX : Type 2 diabetes mellitus without complications
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p> <p

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/21/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Tarnisha Fitzgerald
7950 Harford Rd
Parkville, MD 21234
PHONE: 8444810217 FAX: 18443101510 NPI: 1164940656

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 : 01/23/2026

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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class="MsoNoSpacing">
 1 - SOC - SN Notes:<o:p></o:p> PT Eval Notes:<o:p></o:p> Physician:<span style="font-size: 10.5pt; background-image: initial; background-position: initial; background-size: initial; background-repeat: initial; background-attachment: initial; background-origin: initial; background-clip: initial;"> Fitzgerald, Tarnisha <o:p> </o:p> <o:p> </o:p>

SN Careplans

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

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 7. Currently taking 5 or more medications, 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; 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: M1700 - Cognition, M1745 - Behavioral Issues, M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, limited range of motion, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, tooth pain/decay/sensitivity

PROCEDURES: home exercise program

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, * how to keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * 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, 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 WALK WITH OUT PAIN IN MY KNEES

GOALS
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

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 keep home safe for patient with dementia
* coping strategies for the caregiver
* recalls related medication(s) purpose, schedule

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 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:	Date
Electronically Signed by Messick, Charles RN	02/21/2026

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PT 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: Pain Interference with ADLs, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene

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: * 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, 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 - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent

PATIENT-STATED GOAL: To have less pain at my right knee when I walk

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower 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	02/21/2026