Home Health Certification and Plan of Care

Order ID: 1150/16753

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
64309747	03/02/2026	From: 03/02/2026 To: 04/30/2026	2794	217058

6. Patient's Name and Address
Fred Gaddy
3142 RAVENWOOD AVE,
BALTIMORE, MD 21213-
410-675-5046

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 06/23/1946 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
G30.1	Alzheimer's disease with late onset	03/02/26

13. ICD	Other Pertinent Diagnoses	Date
F02.811	Dem in other dis classd elswhr unsp severt with agitation	03/02/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	03/02/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	03/02/26
N18.30	Chronic kidney disease stage 3 unspecified	03/02/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	03/02/26
D64.9	Anemia unspecified	03/02/26
E78.5	Hyperlipidemia unspecified	03/02/26
G40.901	Epilepsy unsp not intractable with status epilepticus	03/02/26
K59.00	Constipation unspecified	03/02/26
K21.9	Gastro-esophageal reflux disease without esophagitis	03/02/26
Z79.899	Other long term (current) drug therapy	03/02/26
Z86.16	Personal history of COVID-19	03/02/26

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

Zestril - Lisinopril 30 mg 0 30mg, 1 tablet by mouth once a day BLOOD PRESSURE
Seroquel - Quetiapine Fumarate eq 50 mg base 0 25mg, take 75 mg , tablet by mouth every 12 hours AGITATION
Norvasc - Amlodipine Besylate eq 5 mg base 0 5mg, 1 tablet by mouth once a day BLOOD PRESSURE
Pioglitazone - Pioglitazone Hydrochloride 15 mg 15MG; 1 TAB by mouth once a day DM

14. DME and Supplies:
walker, cane

15. Safety Measures:
ambulates with device, walker precautions, , supervision at all times, transfer with assist, remove environmental barriers, activity supervision

16. Nutrition:
low cholesterol, low sodium, diabetic

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Exercises Prescribed, Cane, Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 3. Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time., ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 8. Patient unable to respond, 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: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Alzheimer'S Disease With Late Onset, 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 was recently transported to the emergency department due to behavioral disturbances and progressively increasing agitation. During the evaluation, the patient's Seroquel dosage was adjusted to 50 mg twice daily, which has since resulted in noticeable improvement, with the patient demonstrating reduced agitation. The patient's past medical history is significant for chronic kidney disease (CKD), dementia, diabetes mellitus (DM), gastroesophageal reflux disease (GERD), hyperlipidemia (HLD), hypertension (HTN), seizure disorder, and a history of right inguinal hernia. Skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> are ordered at a frequency of once weekly for 12 weeks, followed by once weekly for an additional week, and then twice weekly for one week. Physical therapy (PT) and occupational therapy (OT) evaluations have been requested, with OT also assigned to assess the need for home health aide (HHA) services. The patient would additionally benefit from a medical social worker (MSW) evaluation to assist with identifying and coordinating appropriate community resources. A follow-up appointment with the patient's primary care provider (PCP) is scheduled for Wednesday. Upon assessment, the patient was alert and oriented to person only (A&O x1) and did not appear to be in acute distress at the time of the visit. Lung sounds were clear to auscultation bilaterally. The patient experiences intermittent urinary incontinence. Bilateral lower extremity edema was observed. The patient ambulates with the assistance of a cane for safety and mobility support. The skilled nurse reviewed all current medications with the patient and spouse, including dosage, frequency, and potential side effects. Special emphasis was placed on the recent increase in Seroquel dosage and monitoring for therapeutic response and adverse effects. The patient's spouse reported understanding of the medication regimen and noted improvement in agitation since the dosage adjustment. The skilled nurse also initiated education related to dementia, including disease progression, safety considerations, and supportive care strategies. The patient's spouse verbalized understanding of the teaching provided. The plan of care includes continued monitoring of the patient's cognitive status, behavioral symptoms, medication effectiveness, safety with ambulation, and overall health status, as well as coordination with therapy services and follow-up with the PCP as scheduled.
 Date of Order 03/02/2026 Orders Physician Face-to-Face Date: 02/25/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, OT eval and treat, PT eval and treat HHA daily adl's, SW community resources. due to Alzheimer'S Disease With Late Onset 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
 Physician Wilson, Marc

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/02/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Marc Wilson
815 E Pratt St
Baltimore, MD 21202
PHONE: 410-637-5700 FAX: 1-410-637-5701 NPI: 1275565251

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 : 02/25/2026

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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SN Careplans

SN WK1: 8 (03/02/26-03/07/26)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 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, 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, Home Safety, meal preparation, M1400 - Dyspnea, swelling in the arms/legs, M1610 - Urinary Incontinence, limited endurance, balance deficit

PROCEDURES: coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion

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 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) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: SPOUSE WOULD LIKE FOR PATIENT TO BE FUNCTIONAL WITH NO AGITATION

GOALS
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
* 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
* 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) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

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

patient's living environment is clean/uncluttered

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/02/2026