Home Health Certification and Plan of Care

Order ID: 1150/17074

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
531039059	03/11/2026	From: 03/11/2026 To: 05/09/2026	23449	217058

6. Patient's Name and Address

Edward Lurz
7826 Saint Fabian Lane,
DUNDALK, MD 21222-
410-790-8062

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 04/17/1950 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
L89.313	Pressure ulcer of right buttock stage 3	03/11/26

13. ICD	Other Pertinent Diagnoses	Date
L89.323	Pressure ulcer of left buttock stage 3	03/11/26
A41.9	Sepsis unspecified organism	03/11/26
S80.812D	Abrasion left lower leg subsequent encounter	03/11/26
L89.896	Pressure-induced deep tissue damage of other site	03/11/26
G20.C	Parkinsonism unspecified	03/11/26
I11.0	Hypertensive heart disease with heart failure	03/11/26
I50.30	Unspecified diastolic (congestive) heart failure	03/11/26
I50.21	Acute systolic (congestive) heart failure	03/11/26
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma	03/11/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	03/11/26
I48.0	Paroxysmal atrial fibrillation	03/11/26
D64.9	Anemia unspecified	03/11/26
I45.81	Long QT syndrome	03/11/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	03/11/26
F32.A	Depression unspecified	03/11/26
Z79.82	Long term (current) use of aspirin	03/11/26
Z87.891	Personal history of nicotine dependence	03/11/26

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

FUROSEMIDE 20 mg / 1 Tablet by mouth in the morning for Heart failure
ESCITALOPRAM 10 mg / 1 Tablet by mouth in the morning for Depression
CHOLESTYRAMINE Oral Packet 4 GM / Give 1 packet by mouth every day and evening shift for Diarrhea
Carbidopa And Levodopa - Carbidopa: Levodopa 25 mg;100 mg / 1 Tablet by mouth three times a day Give 2.5 tablet for Parkinson disease
Aspirin - Aspirin Chewable 81 mg / 1 Tablet by mouth in the morning for CVA prophylaxis
Atorvastatin Calcium - Atorvastatin Calcium 40 mg / 1 Tablet by mouth at bedtime for HLD
Lisinopril - Lisinopril 40 mg / 1 Tablet by mouth in the morning for HTN
Metformin Hcl - Metformin Hydrochloride ER 500 mg / 1 Tablet by mouth in the evening for DM
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg / 1 Capsule by mouth at bedtime Give 2
Therapeutic M - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox / 1 Tablet by mouth in the morning for Supplement
Vitamin D (cholecalciferol) Oral Tablet 50 MCG (2000 UT) / 1 Tablet by mouth in the morning for Vitamin D Deficiency

14. DME and Supplies:

wheelchair, rolling walker, hand held shower, diabetic supplies, bath bench, walker, grab bars, commode, cane, 4 wheeled walker

15. Safety Measures:

walker precautions, smoke detectors , , , , diabetic precautions, , ambulates with device, ambulates with assistance, emergency phone # clearly displayed, supervision at all times, transfer with assist, wheelchair precautions, , hand rails, bathroom safety, activity supervision

16. Nutrition:

low sodium

17. Allergies:

morphine vanomycins

18.A. Functional Limitations

Ambulation, Bowel/Bladder Incontinence, Endurance

18.B. Activities Permitted

Walker, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: 4. 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!5. Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)!6. Delusional, hallucinatory, or paranoid behavior, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

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 Pressure Ulcer Of Right Buttock Stage 3, 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 75-year-old male with a significant past medical history including Parkinsonism, coronary artery disease, hypertension, type 2 diabetes mellitus, paroxysmal atrial fibrillation, heart failure with preserved ejection fraction (HFpEF), benign prostatic hyperplasia, depression, and chronic stage 3 bilateral buttock pressure ulcers. He was recently hospitalized from 02/11/2026 to 02/19/2026 for sepsis in the setting of atrial fibrillation with rapid ventricular response and suspected pneumonia. During hospitalization, he received antibiotic therapy, including a course of amoxicillin/clavulanate (Augmentin) completed on 02/23/2026, along with supportive medical management, resulting in clinical improvement. He was subsequently transferred to a skilled nursing facility for continued rehabilitation, medication optimization, and wound care prior to discharge home. At the time of assessment, the patient reports persistent soreness in the bilateral buttock region associated with chronic pressure ulcers but denies fever, chest pain, or shortness of breath. He notes improved appetite and sleep since discharge. The patient is alert and medically stable, with all prescribed medications available in the home. He remains a full code. Ongoing concerns include impaired mobility, fall risk, and deconditioning, particularly in the context of Parkinsonism and recent acute illness. The patient resides in a townhome with his spouse, who is involved in his care, and has a household pet. Skilled therapy services have been ordered to address deficits in strength, balance, and mobility, with a focus on fall prevention and functional independence. Continued wound care management is indicated for chronic stage 3 pressure ulcers, along with monitoring for signs of infection or deterioration. Education should be reinforced regarding pressure relief strategies, medication adherence, and recognition of worsening symptoms. The plan of care includes ongoing interdisciplinary management to support recovery, prevent rehospitalization, and optimize the patient's functional status within the home environment.
 Date of Order 03/11/2026 Orders Physician Face-to-Face Date: 02/20/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN Med management, wound care PT eval and treat OT eval and treat due to Pressure Ulcer

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/11/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Robert Levine
2391 Greenspring Drive
Timonium, MD 21093
PHONE: 410-847-3000 FAX: 18554160980 NPI: 1417274432

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 : 02/20/2026

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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Of Right Buttock Stage 3 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 Levine , Robert

SN Careplans

SN WK1: 1 (03/11/26-03/14/26)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (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, 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: M1720 - Anxiety, M1745 - Behavioral Issues, M1700 - Cognition, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, M2020 - Oral Med Management, dependent edema, M1400 - Dyspnea, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, M1620 - Bowel Incontinence, M1610 - Urinary Incontinence, foul-smelling urine, urine retention, limited endurance, muscle spasms, swelling of affected area, limited strength, poor muscle tone, limited range of motion, muscle weakness, daytime fatigue, difficulty sleeping, lethargy, B1000 - Vision Deficit, impaired speech, balance deficit, involuntary movement of extremity, weak hand grips, loss of appetite

PROCEDURES: incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange resources for vision-impaired

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to keep

SN Goals

PATIENT-STATED GOAL: Care giver states she wants patient to be able to walk again

GOALS
patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* 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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

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) purpose, schedule

patient/caregiver recalls
* strategies to increase caloric intake
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* 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/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 patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/11/2026

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anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, * strategies to increase caloric intake, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, 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 patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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