Home Health Certification and Plan of Care

Order ID: 1150/17445

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
231286539	03/23/2026	From: 03/23/2026 To: 05/21/2026	3117	217058

6. Patient's Name and Address
Ernest Holtman
7548 Old Telegraph Rd. Apt. 108,
HANOVER, MD 21076-
307-679-1800

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 03/24/1936 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I50.9	Heart failure unspecified	03/23/26

13. ICD	Other Pertinent Diagnoses	Date
S09.92XD	Unspecified injury of nose subsequent encounter	03/23/26
N18.9	Chronic kidney disease u	03/23/26
I48.0	Paroxysmal atrial fibrillation	03/23/26
E03.9	Hypothyroidism unspecified	03/23/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	03/23/26
Z79.01	Long term (current) use of anticoagulants	03/23/26
Z91.81	History of falling	03/23/26

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

Famotidine - Famotidine 20mg, oral by mouth once a day
Levothyroxine - Levothyroxine Sodium 100 mcg, oral by mouth once a day before breakfast
Acetaminophen - Acetaminophen 650mg, tablet by mouth as necessary
Centrum Silver - Ascorbic Acid: Biotin: Cyanocobalamin: Ergocalciferol: Folic Acid: Niacinamide: Pantothenic Acid: Phytonadione: Pyridoxine: Ribo 1 tablet by mouth once a day Supplement
Caltrate Plus D - Calcium Acetate 1 tablet by mouth twice a day supplement calcium carbonate powder by mouth as necessary
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg capsule 1capsule by mouth at bedtime
Carvedilol - Carvedilol 3.125 mg 1 tablet by mouth twice a day With meal, for heart health and blood pressure
Atorvastatin - Atorvastatin Calcium 40mg, oral by mouth once a day
Furosemide - Furosemide 20 mg 1 tablet by mouth as necessary Take as needed when you have ankle and leg swelling.
Pradaxa - Dabigatran Etexilate Mesylate 75 mg 1 cap by mouth twice a day

14. DME and Supplies:
hand held shower, rolling walker, grab bars, cane

15. Safety Measures:
transfer with assist, supervision at all times, , , , avoid temperature extremes, ambulates with device, , ambulates with assistance, walker precautions, smoke detectors , , bathroom safety, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
pcn

18.A. Functional Limitations
Ambulation

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

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., 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: good

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: 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
another facility/provider will be responsible for managing treatment

Homebound status: Due to diagnosis of Heart Failure Unspecified, 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:

Start of care (SOC) and physical therapy admission were completed for a 90-year-old male residing in an assisted living facility (ALF) following a recent fall approximately one month prior, with referral initiated by Dr. Kenneth Villar. The patient has a complex past medical history including hypothyroidism, hiatal hernia, gastroesophageal reflux disease (GERD), right carotid stenosis status post carotid endarterectomy (2019), atrial fibrillation managed with apixaban (Eliquis), congestive heart failure (CHF), chronic kidney disease stage 3, benign prostatic hyperplasia (BPH), obstructive sleep apnea (OSA), history of cerebrovascular accident (CVA) with residual deficits including dysphagia and impaired mobility, orthostatic hypotension, prior COVID-19 infection (2024), and history of prostate cancer treated with brachytherapy. Additional concerns include a prior seizure episode in 2024, presyncopal episodes likely related to hypovolemia, cataracts (not surgically corrected), urinary incontinence with poor awareness, and chronic left hand pain rated at 5/10. The patient resides in a single-level ALF with 24-hour care available. His daughter, who is currently assisting temporarily, reports that the patient has experienced two falls since January 2026 and demonstrates memory deficits, including difficulty adhering to toileting routines and safety recommendations such as consistent use of a walker. The patient is able to follow directions but exhibits decreased safety awareness. He requires assistance for bathing and supervision for other activities of daily living (ADLs), while instrumental activities of daily living (IADLs), including financial management, are performed with daughter oversight. Although previously more active within the facility, the patient now spends most of his time in his room. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient presents with decreased bilateral lower extremity strength, impaired balance, unsteady gait, decreased functional mobility, difficulty with transfers, and increased fall risk. He ambulates within the facility without an assistive device but requires standby assistance and verbal cues for safety, including improved step height and length. He has a documented history of multiple falls and demonstrates decreased safety awareness, further increasing risk for injury. Medication reconciliation was completed, and patient education was provided on home safety, fall prevention strategies, and risk factor modification per the home health handbook. Additional instruction included edema management through lower extremity elevation and use of compression garments as ordered by the physician. The patient was educated on safe ambulation techniques and the importance of initiating a structured walking program, beginning with short, frequent ambulation sessions every 1-2 hours and gradually progressing duration as tolerated to improve circulation and prevent deconditioning. He demonstrated understanding of the education provided. Physical therapy services are ordered at a frequency of twice weekly for three weeks followed by once weekly for four weeks (2w3, 1w4) to address deficits in strength, balance, mobility, transfers, and safety awareness, with the goal of restoring functional independence and reducing fall risk. Occupational therapy services are also recommended to address ADL performance, cognitive safety awareness, continence management, and functional activity tolerance. The patient is considered homebound due to high fall risk, history of falls, cognitive impairment, and the need for assistance and supervision to safely leave the home environment. The interdisciplinary plan of care has been reviewed with the patient and caregiver, both of whom are in agreement, and the referring physician has been notified of the completed admission.
 Date of Order 03/23/2026 Orders Physician Face-to-Face Date: 03/12/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT: <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">Assessment</mh> & treatment, Occupational Therapy: ADL training; Energy conservation due to Heart Failure Unspecified 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 - PT Notes: soc OT Eval Notes:
 Physician Villar, Kenneth

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

25. Date HHA Received Signed POT

24. Physician's Name and Address
Kenneth Villar
7670 Quarterfield Road
Glen Burnie, MD 21061
PHONE: FAX: NPI: 1235314436

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 : 03/12/2026

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.

Home Health Certification and Plan of Care

Order ID: 1150/17445

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
231286539	03/23/2026	From: 03/23/2026 To: 05/21/2026	3117	217058

6. Patient's Name and Address
Ernest Holtman
7548 Old Telegraph Rd. Apt. 108,
HANOVER, MD 21076-
307-679-1800

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

SN Careplans

SN Goals

PT Careplans

PT WK1: 2 (03/23/26-03/28/26) ,WK3: 2 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26) ,WK6: 1 (04/26/26-05/02/26) ,WK7: 1 (05/03/26-05/09/26)

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), 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 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

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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, 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, GG0170E1 - Chair to Bed to Chair, GG0170F1 - Toilet Transfer, M1745 - Behavioral Issues, M2020 - Oral Med Management, M2102d - Caregiver Performs Treatment, M1033 - Unintentional Weight Loss, M1400 - Dyspnea, lung sounds not clear, swelling in the arms/legs, muscle weakness, balance deficit, swelling in legs/around eyes

PROCEDURES: home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., dynamic standing

PT Goals

PATIENT-STATED GOAL: I want to be able to walk without my walker

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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

caregiver performs medical/rehabilitation treatments with adequate competence

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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
03/23/2026

Home Health Certification and Plan of Care

Order ID: 1150/17445

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
231286539	03/23/2026	From: 03/23/2026 To: 05/21/2026	3117	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Ernest Holtman 7548 Old Telegraph Rd. Apt. 108, HANOVER, MD 21076- 307-679-1800	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention

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, * 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver performs medical/rehabilitation treatments with adequate competence, 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

OT Careplans

OT WK1: 1 (03/23/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26) ,WK6: 1 (04/26/26-05/02/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, 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: cough/deep breathing exercises, equipment training, work simplification/energy conservation

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 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: To improve balance / coordination

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
* 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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

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	03/23/2026