Home Health Certification and Plan of Care

Order ID: 1150/17438

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
381036610	03/23/2026	From: 03/23/2026 To: 05/21/2026	23840	217058

6. Patient's Name and Address

Charles Gabourel
7904 Gentle Breeze Ct Apt A,
GLEN BURNIE, MD 21061-
301-276-1680

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 03/24/1957 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
S91.301D	Unspecified open wound right foot subsequent encounter	03/23/26

13. ICD	Other Pertinent Diagnoses	Date
S91.104D	Unsp opn wnd right lesser toe(s) w/o damage to nail subs	03/23/26
S80.11XD	Contusion of right lower leg subsequent encounter	03/23/26
I10.	Essential (primary) hypertension	03/23/26
D62.	Acute posthemorrhagic anemia	03/23/26
E78.5	Hyperlipidemia unspecified	03/23/26
I95.9	Hypotension unspecified	03/23/26
M71.21	Synovial cyst of popliteal space [Baker] right knee	03/23/26
M71.22	Synovial cyst of popliteal space [Baker] left knee	03/23/26
E66.01	Morbid (severe) obesity due to excess calories	03/23/26
Z79.01	Long term (current) use of anticoagulants	03/23/26
Z86.718	Personal history of other venous thrombosis and embolism	03/23/26
Z86.711	Personal history of pulmonary embolism	03/23/26
Z85.46	Personal history of malignant neoplasm of prostate	03/23/26

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

Lipitor - Atorvastatin Calcium eq 40 mg base eq 40 mg base / 1 Tablet by mouth once a day for cholesterol and heart protection
Warfarin - Warfarin Sodium 3mg; 1 tab by mouth at bedtime blood thinner
Acetaminophen - Acetaminophen 325 mg 325mg; 2 tabs by mouth every 6 hours as needed for pain
Biscodyl - Bisacodyl: Polyethylene Glycol 3350: Potassium Chloride: Sodium Bicarbonate: Sodium Chloride 5mg; 1 tab by mouth once a day bowel movement
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg; 1 tab by mouth every 4 hours as needed for pain

14. DME and Supplies:

bath bench, walker, wound care supplies, cane

15. Safety Measures:

ambulates with device, walker precautions, , infectious material management,

16. Nutrition:

cardiac diet,

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Walker, Exercises Prescribed

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: 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

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Unspecified Open Wound Right Foot Subsequent Encounter, 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 with a complex medical history significant for recurrent pulmonary embolism, leukopenia, electrolyte and nutritional abnormalities, transaminitis, chronic right foot/toe wounds, bilateral Baker's cysts, hypertension, hyperlipidemia, severe obesity, history of prostate cancer, and overall deconditioning. The patient was admitted to the hospital on February 12, 2026, following a fall outside his apartment, which resulted in a large right lower extremity (RLE) hematoma. He subsequently underwent incision and drainage (I&D) with evacuation and initiation of negative pressure wound therapy (wound VAC), complicated by acute blood loss anemia and marked troponin elevation. The patient is currently maintained on warfarin 3 mg daily, with the most recent INR drawn the previous Friday, and has scheduled follow-up appointments with the Kaiser anticoagulation clinic and primary care provider. The patient resides alone in a single-level apartment with environmental barriers including four steps to enter the building and an additional six steps leading to his basement-level unit. He receives intermittent assistance from his sister as needed. He is considered homebound due to increased fall risk, need for assistive device use, and requirement for assistance to safely leave the home. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient is alert and oriented, demonstrates intact cognition, and denies pain at the time of visit, although he reports shortness of breath with moderate exertion. Lung sounds are clear throughout. Physical examination reveals +3 edema and hemosiderin staining of the right lower extremity. The patient ambulates using a walker for safety and reports one fall within the past year. He is modified independent with basic activities of daily living (BADLs) and dependent for instrumental activities of daily living (IADLs). Wound care is ongoing for the RLE surgical site with a wound VAC in place; the patient is able to perform rescue dressing changes in the event of device malfunction. Skilled nursing services are ordered at a frequency of three times per week for eight weeks (3w8) for wound management, medication monitoring, and clinical <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>. During the visit, wound care was performed without complication. The patient was educated on medication regimen, including dosing, frequency, and potential side effects of warfarin, as well as signs of bleeding and when to notify the nurse or physician. Additional education was provided regarding wound VAC management, including canister changes, rescue dressing procedures, and signs and symptoms of infection such as fever, redness, swelling, drainage, or increased pain, with the patient demonstrating understanding. Physical therapy evaluation identified deficits including decreased bilateral lower extremity strength, impaired balance, unsteady gait, difficulty with transfers and stair negotiation, decreased safety awareness, and increased fall risk. The patient also reports chronic left knee pain with occasional buckling and longstanding left shoulder rotator cuff pain limiting end range of motion. He requires minimal assistance to standby assistance for transfers and standby assistance for ambulation with a walker on level surfaces, with cues required for proper technique and safety. Standardized <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>s, including Tinetti and Timed Up and Go (TUG), were performed to evaluate fall risk. The patient was instructed in safe transfer techniques, proper use of assistive devices, and gait training, including improving step height and length. Education was also provided on fall prevention strategies, home safety modifications, and the importance of consistent use of the walker. The patient was further instructed on edema management, including elevation of lower extremities above heart level during rest and potential use of compression garments as recommended by the physician. A progressive walking program was initiated, encouraging short, frequent ambulation sessions with gradual increases in duration as tolerated to improve circulation and prevent

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

Ashish Ahuja
22 South Greene St
Baltimore, MD 21201
PHONE: FAX: NPI: 1982067260

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.

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complications of immobility. Pain management education included appropriate use of medications, monitoring for side effects such as dizziness and constipation, and timing medication prior to therapy sessions for optimal participation. The patient was also instructed to apply ice to the left knee for 20 minutes with appropriate skin protection. Occupational therapy services will assess the need for a home health aide and address functional deficits in ADLs, upper extremity limitations, and safety. The interdisciplinary plan of care includes skilled nursing, physical therapy, and occupational therapy to improve strength, mobility, safety, and independence while reducing fall risk and preventing further functional decline. The patient and caregiver were actively involved in care planning and verbalized understanding and agreement with the established plan of care.
 Date of Order 03/23/2026 Orders Physician Face-to-Face Date: 03/12/2026 Clinical Condition Requiring Home Care per Certifying Physician: SHN PT/OT/HA and RW and Wound VAC with a canister for Negative Pressure due to Unspecified Open Wound Right Foot Subsequent Encounter 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 Ahuja, Ashish

SN Careplans

SN WK1: 3 (03/23/26-03/28/26) ,WK2: 3 (03/29/26-04/04/26) ,WK3: 3 (04/05/26-04/11/26) ,WK4: 3 (04/12/26-04/18/26) ,WK5: 2 (04/19/26-04/25/26)

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: 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 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: M2020 - Oral Med Management, Home Safety, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, limited range of motion, swelling of affected area, limited strength, limited endurance, Pain Interference with ADLs, balance deficit, obesity, discolored patches of skin, rough/scaly/cracked skin, open sores/lesions, #1 - Open Wound - Anterior Right Below Knee - , #2 - Abrasion - Anterior Right Below Knee - Skin tear adhesive related injury

PROCEDURES: physician-ordered wound care: #1 - Open Wound - Anterior Right Below Knee -, cough/deep breathing exercises, wound vacuum: RLE WOUND CARE; CLEANSE WITH NSS, BLACK FOAM; SKIN PREP TO PERIWOUND; 125MMGHG CONTINUOUS MWF. RESCUE DRESSING IS NSS W-D DAILY; PT TAUGHT RESCUE DRESSING, 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 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound

SN Goals

PATIENT-STATED GOAL: I WANT WOUND TO HEAL

GOALS
patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* 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
* 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

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* 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

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/23/2026

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measurements, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 2 (03/23/26-03/28/26) ,WK2: 2 (03/29/26-04/04/26) ,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)

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, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., therapeutic modalities: Apply ice to L knee x 20 minutes with necessary barrier and skin assessments q 5 minutes., work simplification/energy conservation, dynamic standing 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/stair training, transfers 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, 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, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: I want to be able to walk out to my car and to be able to drive

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

Upper Body Dressing - 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: 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, incentive spirometer, 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, 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: To return to plof, able to drive

GOALS
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

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	03/23/2026