Home Health Certification and Plan of Care

Order ID: 1150/17598

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
4HD7GD5NQ43	03/26/2026	From: 03/26/2026 To: 05/24/2026	23916	217058

6. Patient's Name and Address

Lincoln Murphy
3333 Windsor Avenue,
Baltimore, MD 21216-
410-421-0431

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 12/04/1963 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
E10.65	Type 1 diabetes mellitus with hyperglycemia	03/26/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	03/26/26
E78.5	Hyperlipidemia unspecified	03/26/26
I48.91	Unspecified atrial fibrillation	03/26/26
I69.322	Dysarthria following cerebral infarction	03/26/26
G40.909	Epilepsy unsp not intractable without status epilepticus	03/26/26
E03.9	Hypothyroidism unspecified	03/26/26
F31.9	Bipolar disorder unspecified	03/26/26
R29.6	Repeated falls	03/26/26
Z79.4	Long term (current) use of insulin	03/26/26
Z79.01	Long term (current) use of anticoagulants	03/26/26
Z79.82	Long term (current) use of aspirin	03/26/26
Z91.81	History of falling	03/26/26

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

Novolog - Insulin Aspart Recombinant LOW DOSE sliding scale subcutaneous before meal
Ergocalciferol - Ergocalciferol 50,000 International Units by mouth once a week
Polyethylene Glycol 3350 - Polyethylene Glycol 3350 17gm/packet by mouth once a day Bowel regimen
Acetaminophen - Acetaminophen 500mg- 2 tablets by mouth every 4 hours Give 2 tablet PRN
Iyuzeh 0.005% Solution right eye at bedtime Glaucoma
ELIQUIS 5 mg / 1 Tablet by mouth twice a day
Triamcinolone - Triamcinolone topical ointment 0.025% topical twice a day
Docusate - Docusate Sodium 100mg tablet by mouth once a day for constipation
Trazodone Hydrochloride - Trazodone Hydrochloride 100 mg by mouth at bedtime
ESCITALOPRAM 5 mg by mouth once a day
Ativan - Lorazepam 1 mg by mouth every 12 hours As needed for anxiety
Valproic Acid - Valproic Acid 250 mg/5ml 750 mg = 15 ml by mouth twice a day
Mobic - Meloxicam 7.5 mg by mouth once a day Pain
Omeprazole - Omeprazole 40 mg by mouth in the morning GERD
Magnesium Oxide - Simethicone 400mg by mouth once a day
Lantus Insulin - Insulin Glargine Recombinant 8 units subcutaneous twice a day
Novolog - Insulin Aspart Recombinant 0.04 ml / 4 units subcutaneous three times a day with meals
Aspirin - Aspirin 81mg by mouth once a day
Atorvastatin - Atorvastatin Calcium 20 mg / 1 Tablet by mouth at bedtime
Albuterol Mdi - Albuterol 1 puff inhalant every 4 hours PRN
Levothyroxine - Levothyroxine Sodium 25 mcg / 1 Tablet by mouth once a day
Levetiracetam - Levetiracetam 100 mg/ml 7.5ml by mouth every 12 hours
Glucose Oral Tablet Chewable 4 g / 1 Tablet by mouth as necessary Give 16 gm = 4 tabs as directed for hypoglycemic episodes
Glucagon - Glucagon Hydrochloride 1 mg/vial intramuscular as necessary as directed
Geodon - Ziprasidone Hydrochloride eq 40 mg base by mouth twice a day
Dorzolamide Hydrochloride - Dorzolamide Hydrochloride eq 2 perc base 1 gtt both eyes twice a day
Dificid - Fidaxomicin 200mg by mouth twice a day 3 days complete.3/30 Infection

14. DME and Supplies:

walker

15. Safety Measures:

bathroom safety, seizure precautions, walker precautions, , , diabetic precautions, , ambulates with device, , activity supervision

16. Nutrition:

pureed, 2gm sodium, diabetic

17. Allergies:

Garlic (Unknown), Pepper (Unknown), Hot Sauce, Tri-Colored Peppers, cefepime

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Walker, Up As Tolerated

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: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

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 Type 1 diabetes mellitus with hyperglycemia, 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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/26/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Koudiratou Radji
6201 Greenbelt Rd Ste M18
Berwyn Heights, MD 20740
PHONE: 3018986483 FAX: 13013293186 NPI: 1699911966

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 : 03/17/2026

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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Clinical Condition Requiring Homecare:

The patient is a 62-year-old male residing in an assisted living facility who was admitted to home health services following a recent short-term hospitalization related to a hypoglycemic episode and seizure activity that resulted in a fall with head injury. The patient's past medical history is significant for atrial fibrillation, <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-hypertension">hypertension</mh>, cerebrovascular accident with residual dysarthria, seizure disorder, syncope, type 1 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-18 CE-FMS-diabetes">diabetes</mh> mellitus, <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-16 CE-FMS-hyperlipidemia">hyperlipidemia</mh>, hypothyroidism, bipolar disorder, and a history of recurrent falls. During the hospitalization, the patient sustained a laceration to the top right portion of his scalp, which was closed with five staples. The wound measures approximately 2.5 cm in length and is currently clean, dry, and well approximated with no signs of infection or drainage. On assessment, the patient is alert and oriented to person, place, time, and situation (A&O x4) and denies pain at this time. Speech is noted to be loud with slurring consistent with residual dysarthria from prior cerebrovascular accident. The assisted living facility manager reports that the patient experiences frequent falls reportedly occurring daily, which are believed to be related to seizure activity; however, the patient attributes his falls to episodes of hypoglycemia. The patient's primary care provider was contacted and has requested that the patient be brought to the office for further evaluation on Friday. The assisted living facility manager has been notified of this request to facilitate transportation and follow-up. Physical assessment revealed lungs clear to auscultation bilaterally and bowel sounds present in all quadrants. The patient reports his last bowel movement occurred the previous evening. He denies chest pain, shortness of breath, dizziness, lightheadedness, nausea, or vomiting. Skin assessment revealed warm, dry, and intact skin with the exception of the stapled scalp wound noted above. Vital signs were obtained and documented, and the patient was admitted to home health services for continued monitoring and care. Functionally, the patient resides in the assisted living facility with a first-floor living setup. He ambulates on indoor surfaces using a rolling walker for approximately 30 feet with supervision and verbal cues to decrease gait speed due to fall risk. Bed mobility is performed with supervision, and transfers to bed, chair, and toilet also require supervision for safety. Outdoor mobility, car transfers, and stair negotiation were not assessed during this visit. The patient is considered homebound due to the significant effort required to leave the home environment with an assistive device and due to impaired balance, as evidenced by a Tinetti Balance and Gait Assessment score of 17/28, indicating an increased risk for falls. During the visit, the patient participated in therapeutic exercises aimed at improving strength and mobility, including supine hip flexion, bridging, hooklying trunk rotation, and hip abduction, as well as seated knee extensions and ankle pumps, performing 10 repetitions of each exercise as tolerated. The patient would benefit from continued skilled home therapy services to improve lower extremity strength, balance, and gait safety, as well as to reinforce pacing strategies and reduce gait speed in order to decrease fall risk and prevent future injury. Education was provided regarding safety, fall prevention strategies, and the importance of monitoring blood glucose levels to reduce hypoglycemic episodes. The plan of care includes ongoing skilled nursing and therapy services to monitor medical status, manage chronic conditions, assess wound healing, and improve functional mobility and safety within the assisted living environment.
 Date of Order 03/26/2026 Orders Physician Face-to-Face Date: 03/17/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN, PT, OT due to Type 1 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-18 CE-FMS-diabetes">diabetes</mh> mellitus with hyperglycemia 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 Radji, Koudiratou

SN Careplans

SN WK1: 1 (03/26/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26)

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), 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.

SN Goals

PATIENT-STATED GOAL: Unable to give a goal at this time

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
* 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 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	03/26/2026

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; 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: D0160 - Depression, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, dizziness/syncope, abnormal BS < 70/140 > mg/dL, limited endurance, limited strength, seizures, balance deficit, tooth pain/decay/sensitivity, #1 - Laceration - Posterior Right Head - 5 staples

PROCEDURES: physician-ordered wound care: #1 - Laceration - Posterior Right Head - 5 staples, glucose testing via monitor

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (03/26/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26) ,WK6: 1 (04/26/26-05/02/26) ,WK8: 1 (05/10/26-05/16/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170N1 - 4 Steps, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170F1 - Toilet Transfer, 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, GG0170D1 - Sit to Stand

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/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet 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, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, 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

PT Goals

PATIENT-STATED GOAL: To be able to walk in the house with my walker and not fall

GOALS
Toilet Transfer - 06. Independent

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

1 - Step (curb) - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

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

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/26/2026