Home Health Certification and Plan of Care

Order ID: 1150/17560

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
21245258	01/30/2026	From: 03/31/2026 To: 05/29/2026	21885	217058

6. Patient's Name and Address

Harold Carver
6 CARAWAY RD APT 3A,
REISTERSTOWN, MD 21136-
410-553-1996

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 07/11/1940 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
J44.1	Chronic obstructive pulmonary disease w (acute) exacerbation	01/30/26

13. ICD	Other Pertinent Diagnoses	Date
G62.9	Polyneuropathy unspecified	01/30/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	01/30/26
N18.4	Chronic kidney disease stage 4 (severe)	01/30/26
N25.81	Secondary hyperparathyroidism of renal origin	01/30/26
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	01/30/26
E78.5	Hyperlipidemia unspecified	01/30/26
E11.36	Type 2 diabetes mellitus with diabetic cataract	01/30/26
H25.9	Unspecified age-related cataract	01/30/26
M54.12	Radiculopathy cervical region	01/30/26
M48.061	Spinal stenosis lumbar region without neurogenic claud	01/30/26
Z79.82	Long term (current) use of aspirin	01/30/26
Z79.4	Long term (current) use of insulin	01/30/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	01/30/26
Z96.651	Presence of right artificial knee joint	01/30/26
Z85.46	Personal history of malignant neoplasm of prostate	01/30/26

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

lancets (ONETOUCH DELICA PLUS LANCET) 30 gauge Misc Misc 30g subcutaneous twice a day
Lisinopril-hydroCHLOROthiazide (PRINZIDE/ZESTORETIC) 20-25 mg Oral Tab 020-25 mg 1tablet by mouth once a day For high blood pressure
insulin glargine-yfgn (SEMGLEE PEN) 100 unit/mL (3 mL) SubQ Insulin Pen 30 units subcutaneous at bedtime Inject 30 Units subcutaneously daily
pen needle, diabetic (ULTRA-FINE PEN NEEDLE) 31 gauge x 5/16 100 each subcutaneous as necessary Use with insulin as directed
blood sugar diagnostic (ONETOUCH VERIO TEST STRIPS) Misc Strips 200 strips subcutaneous three times a day Check blood sugar in the morning before breakfast and in the evening before dinner
Lipitor - Atorvastatin Calcium eq 40 mg base eq 40 mg base by mouth once a day
Pepcid - Famotidine 20 mg 20 mg1 tablet by mouth at bedtime
Kirsty insulin injection 100 unit/ml (3 mL) subcutaneous three times a day Inject 6 units subcutaneously 3 times a day for DM
Albuterol - Albuterol 90 mcg/inh inhalant every 4 hours Inhale 2 puffs by mouth every 4 hrs by mouth of sob, wheezing or cough
Spiriva Respimat - Tiotropium Bromide 2.5 mcg/actuation inhalant once a day 2 puffs by my daily
Furosemide - Furosemide 20 mg by mouth once a day For fuild
Amilodipine - Amlodipine Besylate 2.5 mg by mouth once a day For HTN

14. DME and Supplies:
rolling walker, commode, cane, bath bench

15. Safety Measures:
diabetic precautions

16. Nutrition:
regular

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation,

18.B. Activities Permitted
No Restrictions

19. Mental & Pyschosocial Status: COGNITION: 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer, ANXIETY: , SOCIAL ISOLATION: 2 independent, BEHAVIORAL ISSUES: 2 independent, HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 2+, MOBILITY: N/A

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

Homebound status: Due to diagnosis of Chronic obstructive pulmonary disease with (acute) exacerbation, 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 an 85-year-old male with a complex past medical history including COPD with recent exacerbation, type 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-18 CE-FMS-diabetes">diabetes</mh> mellitus with peripheral neuropathy, chronic kidney disease (stages 3-4), lumbar spinal stenosis with neurogenic claudication, cervical radiculopathy, <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-hypertension">hypertension</mh>, <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-16 CE-FMS-hyperlipidemia">hyperlipidemia</mh>, right inflammatory glaucoma, prostate cancer, and a history of falls. He lives with his son in a two-bedroom apartment, while his daughter manages his healthcare and finances. The patient was admitted to home health to resume skilled physical therapy services following a decline in functional mobility related to worsening neuropathy and gait impairment. On assessment, he was alert and oriented and reported bilateral lower-extremity neuropathic pain rated 4-5/10. Skin was warm and intact with palpable pulses and no lower-extremity edema; lung assessment revealed crackles throughout. He ambulates short household distances using a rollator with standby assistance but demonstrates difficulty rising from a seated position, bilateral lower-extremity weakness (grossly 3/5), impaired balance (static standing fair minus, dynamic standing poor), and altered gait mechanics, placing him at high fall risk. He denies shortness of breath at rest but becomes easily dyspneic with ambulation beyond 20 feet and has not left the home since a fall last year, requiring assistance to negotiate stairs. Functional deficits impact bed mobility, transfers, and ADLs, with the patient requiring setup assistance for upper-body dressing, contact guard to minimal assistance for lower-body dressing, bathing, and toileting, and demonstrating bilateral upper-extremity weakness (4-/5). Skilled home health physical therapy is medically necessary to address lower-extremity strengthening, balance and gait training, transfer training, fall risk reduction, and functional mobility to improve safety and independence within the home. The patient demonstrates fair rehabilitation potential, supported by caregiver involvement and prior benefit from home physical therapy.
 Date of Order 03/26/2026 Orders Physician Face-to-Face Date: 01/26/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha msw due to Chronic obstructive pulmonary disease with (acute) exacerbation Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 4 - Recertification Notes: The patient is a 85 year old man who can continue to benefit from continued OT services to address ADLs, transfers, balance and bilateral upper extremity muscle strength. Patient is limited secondary to weakness of upper and bilateral upper and difficulty with balance. Physician Mason, Sherell

SN Careplans
SN WK1: 1 (03/31/26-04/04/26)

SN Goals

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
Sherell Mason
815 E. Pratt Street
Baltimore, MD 21202
PHONE: 410-637-5700 FAX: 14106375661 NPI: 1750375481

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 : 01/26/2026

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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OT Careplans

OT WK2: 1 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26) ,WK4: 1 (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, blood sugar < 60 > 300

CAREGIVER:

HOSPITALIZATION RISKS: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 4. Multiple emergency department visits (2 or more) in the past 6 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: abnormal blood pressure, M1033 - Unintentional Weight Loss, limited strength, balance deficit

PROCEDURES: Patient/caregiver recalls related purpose and schedule of medications: Medication review

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 medicatio, * 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 relaxatio, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * strategies to increase caloric intake, 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: Patient wants his legs and arms to get stronger

GOALS
Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

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

Eating - 06. Independent

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 relaxatio

Oral Hygiene - 06. Independent

Upper Body Dressing - 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 medicatio

Shower/Bathe Self - 04. Supervision or touching assistance

HHA Careplans

HHA WK1: 1 (03/31/26-04/04/26) ,WK2: 1 (04/05/26-04/11/26)

HHA Goals

Signature of Physician:

Date

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

Date
03/26/2026