Home Health Certification and Plan of Care

Order ID: 1150/17926

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
661058831	03/27/2026	From: 03/27/2026 To: 05/25/2026	23993	217058

6. Patient's Name and Address
James Kutlik
19 CEDARMERE ROAD,
OWINGS MILLS, MD 21117
443-501-6393

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 08/20/1960 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I11.0	Hypertensive heart disease with heart failure	03/27/26

13. ICD	Other Pertinent Diagnoses	Date
I50.33	Acute on chronic diastolic (congestive) heart failure	03/27/26
I42.8	Other cardiomyopathies	03/27/26
J44.9	Chronic obstructive pulmonary disease unspecified	03/27/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	03/27/26
E78.5	Hyperlipidemia unspecified	03/27/26
G25.81	Restless legs syndrome	03/27/26
M19.90	Unspecified osteoarthritis unspecified site	03/27/26
Z79.82	Long term (current) use of aspirin	03/27/26
Z87.891	Personal history of nicotine dependence	03/27/26

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

Aspirin - Aspirin 81 mg by mouth once a day
Iron - Ferrous Sulfate: Folic Acid 325mg by mouth once a day
Atorvastatin - Atorvastatin Calcium 40 mg by mouth in the evening
Jardiance - Empagliflozin 10mg by mouth once a day
Amiodarone - Amiodarone Hydrochloride 400 mg by mouth once a day
Losartan Potassium - Losartan Potassium 25 mg by mouth once a day
FUROSEMIDE 20 mg 20 mg by mouth once a day
CARVEDILOL 6.25 mg 6.25 mg by mouth twice a day with meals
Acetaminophen - Acetaminophen 650 mg by mouth once a day

14. DME and Supplies:
None of the above

15. Safety Measures:
fall precautions, medication safety, cardiac precautions

16. Nutrition:
cardiac diet

17. Allergies:
bupropion penicillin penicilin g varenicline

18.A. Functional Limitations
None of the above

18.B. Activities Permitted
Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

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
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive heart disease with heart failure, 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 65-year-old male admitted to home health services following a recent short stay at an acute care facility related to hypotension, lactic acidosis, and tachycardia. His past medical history is significant for congestive heart failure with a severely reduced ejection fraction of 20-25%, coronary artery disease, chronic obstructive pulmonary disease (COPD), bullous emphysema status post lung resection, and chronic cocaine use. The patient is alert and oriented 4 and denies pain at the time of <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>. On examination, lung sounds are diminished bilaterally, peripheral pulses are palpable in all extremities, and bowel sounds are present with the patient reporting his last bowel movement occurred the previous day. Oxygen saturation levels are noted to be 93-94% on room air. Although the patient has been prescribed supplemental oxygen, he reports noncompliance with its use. He denies shortness of breath, dizziness, or lightheadedness at this time. The patient resides alone, with intermittent assistance provided by his sisters who live nearby. Given the patient's significant cardiopulmonary history and recent acute episode, skilled home health services are warranted for close monitoring of cardiovascular and respiratory status, reinforcement of oxygen therapy compliance, and education regarding disease management. Patient education should focus on the importance of adhering to prescribed oxygen use, recognizing signs and symptoms of worsening heart failure or respiratory distress, medication adherence, and lifestyle modifications. The plan of care includes ongoing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, monitoring for potential exacerbations, and coordination with the healthcare team to optimize the patient's stability and reduce risk of rehospitalization.
 Date of Order 03/27/2026 Orders Physician Face-to-Face Date: 03/19/2026 Clinical Condition Requiring Home Care per Certifying Physician: Skilled Nursing Monitor medication compliance, vitals and doctor follow up appointments due to Hypertensive heart disease with heart failure 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 (03/27/26-03/28/26) ,WK2: 2 (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) ,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: 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

SN Goals

PATIENT-STATED GOAL: I want to drive again.

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

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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/27/2026

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 : 03/19/2026

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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hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; 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: D0700 - Social Isolation, M2020 - Oral Med Management, M1400 - Dyspnea, delayed capillary refill, lung sounds not clear, tooth pain/decay/sensitivity, itchy skin, pallor

PROCEDURES: cough/deep breathing exercises, coordinate/arrange long-term socialization activities

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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/27/2026