Home Health Certification and Plan of Care

Order ID: 1150/18034

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
86245524	04/11/2026	From: 04/11/2026 To: 06/09/2026	24674	217058

6. Patient's Name and Address

Sang Jeon
8030 Brightfield Rd,
ELLICOTT CITY, MD 21043-
410-300-9380

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 07/03/1961 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
N39.0	Urinary tract infection site not specified	04/11/26

13. ICD	Other Pertinent Diagnoses	Date
S01.80XD	Unspecified open wound of other part of head subs encntr	04/11/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	04/11/26
I10.	Essential (primary) hypertension	04/11/26
K21.9	Gastro-esophageal reflux disease without esophagitis	04/11/26
E78.5	Hyperlipidemia unspecified	04/11/26
N40.1	Benign prostatic hyperplasia with lower urinary tract symp	04/11/26
R33.8	Other retention of urine	04/11/26
R13.10	Dysphagia unspecified	04/11/26
E66.811	Obesity class 1 (E66.811	04/11/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	04/11/26
Z79.4	Long term (current) use of insulin	04/11/26
Z79.891	Long term (current) use of opiate analgesic	04/11/26
Z87.01	Personal history of pneumonia (recurrent)	04/11/26
Z89.512	Acquired absence of left leg below knee	04/11/26

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

PANTOPRAZOLE 40 mg tablet,delayed release (DR/EC) by mouth one time a day for GERD BEFORE BREAKFAST
POTASSIUM 20 mEq tablet extended release by mouth in the morning for HYPOKALEMIA
AMLODIPINE 10 mg tablet by mouth in the morning for HTN (HOLD FOR SBP < 110
GUAIFENESIN 100 mg/5 mL liquid by mouth every 4 hours as needed for COUGH/CONGESTION .
ATORVASTATIN 40 mg tablet by mouth at bedtime for HLD
OXYCODONE 5 mg tablet by mouth every 6 hours as needed for 14 Days for Pain
GABAPENTIN 600 mg tablet by mouth three times a day for Neuropathy
BARRIER CREAM topically every shift Apply to BUTTOCKS AND PERI AREA for Skin Protection AFT SOAP/H20
MAGNESIUM 400 mg/5 mL suspension by mouth every 24 hours as needed for CONSTIPATION IF NO BM IN 2 DAYS
DULCOLAX 10 mg suppository rectally every 24 hours as needed for BOWEL MANAGEMENT IF NO BOWEL MOVEMENT IN 3 DAYS - NOTIFY MD IF INEFFECTIVE
FUROSEMIDE 40 mg tablet by mouth in the morning for CHF 1.5tab=60mg
METFORMIN 500 mg tablet by mouth two times a day for DIABETES TAKE WITH FOOD TO AVOID GI UPSET
BETADINE 10% solution topically every day shift Apply to L cheek & upper outer lip for wound care CLEANSE WITH NSS, PAT DRY APPLY BETADINE TO SCAB ONLY AND LOTA
Novolog 70/30 Insulin - Insulin Recombinant Purified Human: Insulin Susp Isophane Semisynthetic Purified Human 100 unit/mL (70-30) solution subcutaneously two times a day for Type 2 DM Hold for BG < 150
Glyxambi - Empagliflozin: Linagliptin 25 mg tablet 1/2 tab by mouth in the morning 1/2 tab for Type 2 DM
DUTASTERIDE AND TAMSULOSIN HYDROCHLORIDE 0.4 mg capsule by mouth at bedtime for BPH
Aspirin - Aspirin 81mg by mouth once a day
Oxygen - Oxygen 2-3L nasal cannula continuous Respiratory support
Betadine - Povidone-Iodine Apply topical once a day

14. DME and Supplies:

wound care supplies, , diabetic supplies, walker, wheelchair

15. Safety Measures:

bathroom safety, transfer with assist, wheelchair precautions, walker precautions, no bp left arm, fall precautions, diabetic precautions, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

diabetic, low cholesterol, low sodium,

17. Allergies:

no known allergies

18.A. Functional Limitations

Amputation, Endurance, Ambulation,

18.B. Activities Permitted

Wheelchair, 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: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

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 Urinary tract infection site not specified, 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 64-year-old Korean-speaking male admitted to home health services following a recent hospitalization for acute hypoxic respiratory failure secondary to multifocal pneumonia, complicated by acute respiratory distress syndrome (ARDS), septic shock, prolonged intubation, and ventilator-associated Klebsiella pneumonia, for which he completed a course of meropenem. His hospital course was further complicated by urinary retention requiring Foley catheter placement, which has since been removed following a successful voiding trial, and he is currently able to void without difficulty. His past medical history is significant for type 2 diabetes mellitus managed with insulin (self-administered per caregiver report), hypertension, hyperlipidemia, peripheral arterial disease, gastroesophageal reflux disease, benign prostatic hyperplasia, end-stage renal disease, obesity, chronic constipation, dysphagia, history of acute kidney failure, recurrent urinary tract infections, and left below-knee amputation (2020) with prosthetic use. At the time of assessment, the patient remains significantly deconditioned with generalized weakness, bilateral lower extremity strength grossly 3/5, impaired dynamic standing balance (Fair-), decreased cardiopulmonary endurance, and altered gait mechanics related to left below-knee amputation and recent critical illness. He requires moderate assistance for bed mobility, transfers, and activities of daily living, with ambulation currently non-functional due to severe deconditioning. The patient utilizes a wheelchair for primary mobility and has access to a walker and left lower extremity prosthesis. He requires supervision and assistive devices for safety, placing him at high risk for falls and rendering him homebound due to taxing effort required to leave the home. He is currently on supplemental oxygen via nasal cannula at 2-3 L/min continuously for respiratory support and dyspnea prevention. The patient resides with his spouse and son in a multi-level home, with access to a step-free rear entrance. His son,

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/11/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Mohammad Rana
1447 York Rd
Lutherville, MD 21093
PHONE: FAX: NPI: 1134278773

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 : 04/02/2026

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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Jason, serves as the primary caregiver and is actively involved in care. The patient demonstrates decreased appetite and ongoing issues with constipation, currently managed with increased use of suppositories; education was provided regarding the initiation of stool softeners to promote bowel regularity. A continuous glucose monitor (Libre 3) is in place on the left upper arm for diabetes management. Skin assessment revealed a scabbed wound measuring approximately 2 x 1.5 cm on the left cheek and upper lip, attributed to prior endotracheal tube placement; no signs of infection were noted. Wound care orders include cleansing with normal saline, patting dry, and applying betadine to the scab daily, which was reviewed with the caregiver. Additionally, the left below-knee amputation site shows irritation but no open wounds; photographs were obtained for documentation. Supplies including normal saline, betadine, gauze, and gloves are to be ordered. The patient also requires a refill of guaifenesin. Functionally, the patient demonstrates significant decline compared to prior level of function, now requiring increased assistance despite previously having a home aide approved in 2022. Skilled nursing, physical therapy, and occupational therapy services are indicated and have been initiated to address medical management, wound care, strength, balance, transfer training, gait training, cardiopulmonary reconditioning, and activities of daily living retraining. Skilled nursing frequency is ordered as 1 visit per week for 1 week, with reassessment for ongoing needs by the covering nurse. The patient has a scheduled follow-up appointment with prosthetic specialists in May. Overall, the patient remains medically complex with significant functional impairment following critical illness. Continued interdisciplinary home health services are medically necessary to improve functional independence, reduce fall risk, optimize chronic disease management, and prevent rehospitalization.
 Date of Order 04/11/2026 Orders Physician Face-to-Face Date: 04/02/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Urinary tract infection site not specified 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 Rana, Mohammad

SN Careplans

SN WK1: 1 (04/11/26-04/11/26) ,WK3: 1 (04/19/26-04/25/26) ,WK4: 1 (04/26/26-05/02/26) ,WK5: 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, blood sugar < 60 > 300

CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

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; 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 ; 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.

Left side cheek and upper lip cleanse with NSS pat dry apply betadine to scab only daily
Advance Directive:Na

PROBLEMS IDENTIFIED ON ASSESSMENT: meal preparation, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, abn cholesterol > 200 mg/dL, abnormal BS < 70/140 > mg/dL, heartburn/indigestion, urine retention, M1600 - UTI, limited strength, limited endurance, muscle weakness, balance deficit, extremity burn/tingle/numb, difficulty sleeping, pain radiating to arms/legs, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, obesity, discolored patches of skin, red/tender pressure points, #1 - Observable Surgical Wound - Anterior Left Below Knee - No open wound, #2 - Other - Anterior Left Face -

PROCEDURES: physician-ordered wound care: #2 - Other - Anterior Left Face -, physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Left Below Knee - No open wound,

SN Goals

PATIENT-STATED GOAL: Get prosthetic to increase mobility

GOALS
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
* 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 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
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/11/2026

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cough/deep breathing exercises, glucose testing via monitor, monitor intake & output, coordinate/arrange preparation of missing meals

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 measurements, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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, meal preparation is available to patient for all meals

PT Careplans

PT WK2: 1 (04/12/26-04/18/26) ,WK3: 2 (04/19/26-04/25/26) ,WK4: 2 (04/26/26-05/02/26) ,WK5: 2 (05/03/26-05/09/26) ,WK6: 1 (05/10/26-05/16/26) ,WK7: 1 (05/17/26-05/23/26) ,WK8: 1 (05/24/26-05/30/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet

PROCEDURES: wheelchair training, home exercise program, 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 - 05. Setup or clean-up assistance, 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, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: To get my strength back

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

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

Toilet Transfer - 05. Setup or clean-up assistance

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

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

Car Transfer - 05. Setup or clean-up assistance

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

OT Careplans

OT WK2: 1 (04/12/26-04/18/26) ,WK3: 1 (04/19/26-04/25/26) ,WK4: 1 (04/26/26-05/02/26) ,WK5: 1 (05/03/26-05/09/26) ,WK6: 1 (05/10/26-05/16/26) ,WK7: 1 (05/17/26-05/23/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, 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, 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, * 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 - 05. Setup or clean-up assistance, 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: Pt wants to be more independent

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 - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Upper Body Dressing - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/11/2026