# Home Health Certification and Plan of Care

**Order ID: 1150/18294**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 611033511 | 04/01/2026 | From: 04/01/2026 To: 05/30/2026 | 24012 | 217058 |

**6. Patient's Name and Address**

Thomas Melvin
4601 W. Northern Parkway 409,
BALTIMORE, MD 21215-
443-378-6979

**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** 07/30/1953 | **9.Sex** Male

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| I12.0 | Hyp chr kidney disease w stage 5 chr kidney disease or ESRD | 04/01/26 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| N18.6 | End stage renal disease | 04/01/26 |
| D63.1 | Anemia in chronic kidney disease | 04/01/26 |
| Z99.2 | Dependence on renal dialysis | 04/01/26 |
| N25.81 | Secondary hyperparathyroidism of renal origin | 04/01/26 |
| E43. | Unspecified severe protein-calorie malnutrition | 04/01/26 |
| K21.9 | Gastro-esophageal reflux disease without esophagitis | 04/01/26 |
| E05.90 | Thyrotoxicosis unsp without thyrotoxic crisis or storm | 04/01/26 |

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

Pantoprazole Sodium - Pantoprazole Sodium 40 mg by mouth twice a day for GERD
Ondansetron Hydrochloride - Ondansetron Hydrochloride eq 4 mg base / 1 Tablet by mouth every 6 hours as needed for Nausea
GABAPENTIN 100 mg by mouth three times a day for Neuropathic pain
Acetaminophen - Acetaminophen 325 mg / 1 Tablet by mouth every 6 hours Give 650 mg as needed for Pain Not to exceed 3 GMs in 24 hours
Calcitriol - Calcitriol 0.5mcg / 1 Capsule by mouth once a day for ESRD until 07/03/2026 23:59
Dialyvite Oral Tablet (B-Complex w/ C & Folic Acid) 1 Tablet by mouth once a day for Supplement
Oxybutynin Chloride - Oxybutynin Chloride 5 mg by mouth twice a day
Amilodipine - Amlodipine Besylate 1 tablet 5 mg by mouth once a day Blood pressure
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 5000 iu by mouth once a day Supplement
FUROSEMIDE 80 mg 80 mg / 1 Tablet by mouth once a day On non dialysis days
Iron - Ferrous Sulfate: Folic Acid 65mg iron, 125 mg vitamin c by mouth once a day Supplement

**14. DME and Supplies:**

hand held shower, walker

**15. Safety Measures:**

ambulates with device, bathroom safety, emergency phone # clearly displayed, smoke detectors , walker precautions, wheelchair precautions, transfer with assist, medication safety, ambulates with assistance, standard precautions, fall precautions, activity supervision

**16. Nutrition:**

Z. NO PHYSICIAN-ORDERED DIET

**17. Allergies:**

NSAIDs

**18.A. Functional Limitations**

Ambulation, Endurance, Bowel/Bladder Incontinence

**18.B. Activities Permitted**

Wheelchair, Transfer bed/Chair, Walker, Exercises Prescribed, Up As Tolerated

**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: Yes

**20. Prognosis:** fair

**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
patient will be responsible for managing treatment
patient will be responsible for managing treatment

**Homebound status:** Due to diagnosis of Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease, 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 72-year-old individual admitted to home health services following a recent hospitalization related to failed peritoneal dialysis and generalized weakness. The patient's past medical history is significant for end-stage renal disease requiring hemodialysis, prior peritoneal dialysis, anemia, gastroesophageal reflux disease, thyrotoxicosis, and malnutrition. The patient currently receives scheduled hemodialysis treatments and has a right chest dialysis catheter in place. Assessment of the catheter site revealed it to be clean, dry, and intact with no signs or symptoms of infection. The patient also has a peritoneal dialysis catheter located in the abdomen that is no longer in use; the site was observed to be intact without redness, drainage, or other complications. At the time of the visit, the patient was alert and oriented to person, place, and time and demonstrated appropriate cognitive function with the ability to communicate needs effectively. The patient resides alone in an elevator-accessible apartment and reports receiving occasional assistance from family and friends as needed. The patient denied pain or acute distress during the assessment. A complete skin assessment was performed, revealing intact skin with no open areas, breakdown, or other abnormalities. Vital signs were obtained and were within acceptable parameters. Functionally, the patient ambulates indoors with a rollator walker for approximately 30 feet on two occasions with supervision for safety. Bed mobility is performed independently, and the patient is able to complete sit-to-stand transfers from the bed, chair, and toilet with supervision. The therapist did not assess outdoor mobility or car transfers during this visit. Due to decreased strength, limited endurance, and the need for an assistive device for mobility, the patient is considered homebound, as leaving the home requires significant effort and assistance. A therapeutic exercise program was initiated to improve strength and functional mobility. The patient demonstrated tolerance to exercises including hip flexion, bridging, hooklying rotation, straight leg raises, hip abduction, knee extension, ankle pumps, standing knee flexion, standing hip abduction, hip extension, heel raises, and squats, completing five repetitions of each exercise with verbal cues provided to ensure proper technique. Written instructions were issued, and the patient was instructed to perform the exercises daily with a goal of completing ten repetitions as tolerated. The patient requires assistance with medication management and continues to demonstrate the need for ongoing education to ensure adherence to the prescribed medication regimen. Skilled nursing services are indicated for continued monitoring of the patient's chronic conditions, assessment of dialysis access sites, medication education, and early identification of potential complications related to end-stage renal disease and dialysis treatment. Education was provided regarding infection prevention, proper care of dialysis access sites, medication compliance, and signs and symptoms that should prompt notification of the healthcare provider. The patient verbalized understanding of the instructions provided. The plan of care includes ongoing skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-visits">visits</mh> for assessment, disease process education, and medication management, as well as skilled therapy services to improve strength, endurance, and functional mobility. The overall goal of care is to maintain medical stability, enhance safety within the home environment, and improve the patient's independence with daily activities while minimizing the risk of complications or functional decline. <br> Date of Order 04/01/2026 Orders Physician Face-to-Face Date: 03/20/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN, PT, OT due to <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-7 CE-FMS-Hypertensive">Hypertensive</mh> chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease Homebound

**23. Signature and Date of Verbal SOC Where Applicable:**

Electronically Signed by Messick, Charles RN on 04/01/2026

**25. Date HHA Received Signed POT**

**24. Physician's Name and Address**

Raymond Dormevil
7141 Security Blvd
Baltimore, MD 21244
PHONE: 443-663-6000 FAX: 14436636215 NPI: 1245627892

**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 : 03/20/2026

**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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Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home <br> 1 - SOC - SN Notes: soc PT Eval Notes: <br> Physician Dormevil, Raymond

## SN Careplans

SN WK1: 1 (04/01/26-04/04/26) ,WK2: 2 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26) ,WK4: 1 (04/19/26-04/25/26) ,WK5: 1 (04/26/26-05/02/26)

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

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/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: M1700 - Cognition, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, Home Safety, Home Safety, M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, M1400 - Dyspnea, M1033 - Exhaustion, M1610 - Urinary Incontinence, limited strength, limited endurance, limited range of motion, B1000 - Vision Deficit, Pain Interference with ADLs, balance deficit

PROCEDURES: train caregiver(s) to perform medical/rehabilitation treatments, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired, monitor dialysis schedule: clinician will describe procedure at time of visits

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 keep home safe for patient with dementia coping strategies for the caregiver*, 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, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient's living environment is clean/uncluttered, patient has access to adequate trash/sewage disposal, 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

## SN Goals

PATIENT-STATED GOAL: Patient stated he would like to be able to manage his medications on his own

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

patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* recalls related medication(s) purpose, schedule

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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

patient's transportation needs are met

patient's living environment is clean/uncluttered

patient has access to adequate trash/sewage disposal

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 | 04/01/2026 |

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## PT Careplans

PT WK1: 1 (04/01/26-04/04/26) ,WK2: 1 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26) ,WK4: 1 (04/19/26-04/25/26) ,WK5: 1 (04/26/26-05/02/26) ,WK6: 1 (05/03/26-05/09/26) ,WK7: 1 (05/10/26-05/16/26) ,WK8: 1 (05/17/26-05/23/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, 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, GG0170E1 - Chair to Bed to Chair

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

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

## PT Goals

PATIENT-STATED GOAL: To walk by myself and get stronger so I can get back from dialysis without using a walker

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

| Signature of Physician: | Date |
|---|---|
| | PAGE 3 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 04/01/2026 |