Home Health Certification and Plan of Care

Order ID: 1150/18430

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
91344835	05/02/2026	From: 05/02/2026 To: 06/30/2026	25385	217058

6. Patient's Name and Address
Ricardo Foreman
1614 Benoli Court,
Odenton, MD 21113-
443-467-5594

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 07/01/1978 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I13.2	Hyp hrt & chr kdny dis w hrt fail and w stg 5 chr kdny/ESRD	05/02/26

13. ICD	Other Pertinent Diagnoses	Date
I50.20	Unspecified systolic (congestive) heart failure	05/02/26
N18.5	Chronic kidney disease stage 5	05/02/26
I42.9	Cardiomyopathy unspecified	05/02/26

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

TERAZOSIN 5 mg / 1 Capsule by mouth nightly Commonly known as: HYTRIN
prostate
AMLODIPINE 5mg; 2 tabs by mouth daily Commonly known as: NORVASC
blood pressure
FUROSEMIDE 20 mg 20 mg / 1 Tablet by mouth once a day Commonly known as: LASIX
fluid pill/blood pressure
HYDRALAZINE 50 mg / 2 Tablet by mouth 3 times daily Commonly known as: APRESOLINE
blood pressure
CARVEDILOL 25 mg 25 mg / 2 Tablet by mouth 2 times daily with meals Commonly known as: COREG
blood pressure/heart

14. DME and Supplies:
None of the above

15. Safety Measures:
standard precautions, medication safety

16. Nutrition:
cardiac diet, 2gm sodium

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
Exercises Prescribed

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: No

20. Prognosis: good

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 and chronic kidney disease with heart failure and 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 47-year-old male recently hospitalized for cardiomyopathy with newly reduced ejection fraction, hypertensive emergency, acute kidney injury (AKI), intermittent chest pain, and shortness of breath. During hospitalization, the patient was noted to have severely elevated blood pressure measuring 236/178 mmHg, with EKG demonstrating nonspecific changes and chest X-ray revealing mild pulmonary vascular congestion. The patient remained hospitalized for approximately five days and returned home on 04/28/2026. Past medical history is significant for hypertension. Skilled nursing services were initiated with planned frequency of 1 visit weekly for 1 week, followed by 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> weekly for 2 weeks, then 1 visit weekly for 3 weeks. Physical and occupational therapy evaluations were also ordered. Patient resides with spouse, Chevena, and children in a three-story townhouse with two steps to enter the home and 12 stairs leading to the main living level. Spouse assists with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed, although patient is frequently alone during the daytime hours. During assessment, the patient was alert and oriented 3, awake, responsive, and able to participate appropriately in care and education. Patient denied chest pain and shortness of breath at the time of the visit. Lung sounds were clear throughout all fields, and no acute respiratory distress was observed. Patient reported good appetite and stated last bowel movement occurred today. Patient endorsed decreased endurance and fatigue with activity but currently ambulates independently without the use of an assistive device both inside and outside the home. No history of falls was reported. Patient reported taking rest breaks during performance of ADLs and IADLs due to reduced endurance and activity tolerance. Functional mobility was assessed as within functional limits, and physical therapy evaluation determined there was no current skilled PT need at this time. Patient agreed with one-time PT evaluation and discharge from physical therapy services. Medication reconciliation and review were completed, including discussion of medication names, dosages, frequencies, purposes, and potential side effects. Skilled nursing initiated education related to cardiomyopathy management, hypertensive disease process, monitoring for worsening symptoms, and importance of adherence to prescribed treatment plan. Patient and spouse were instructed on daily weight monitoring, recognizing signs and symptoms requiring physician or nursing notification, and parameters for seeking emergent care, including worsening shortness of breath, chest pain, sudden weight gain, edema, dizziness, or severe blood pressure elevation. Both patient and spouse verbalized understanding of all teaching provided. Occupational therapy assessment identified decreased endurance and need for intermittent rest breaks during BADLs despite the patient remaining largely independent in functional mobility and self-care tasks. Skilled occupational therapy services were determined to be medically necessary to prevent deconditioning, maintain independence, improve activity tolerance, and enhance overall quality of life. During one OT visit, patient was noted to have significantly elevated blood pressure readings of 185/127 mmHg at the start of the visit and 178/127 mmHg at the conclusion of the session, though he remained asymptomatic throughout. Kaiser was contacted, and a message was sent to the physician regarding the elevated readings. Patient additionally reported feelings of congestion over the past several days while hospitalized. A kidney biopsy had been ordered, and patient reported a scheduled follow-up appointment the following morning. Home environment includes a walk-in shower, and patient continues to pace activities carefully while incorporating rest periods as needed. Ongoing skilled nursing and occupational therapy services remain indicated for cardiopulmonary monitoring, blood pressure management, medication education, endurance training, prevention of deconditioning, and reinforcement of disease process management and safety awareness.
 Date of Order 05/02/2026 Orders Physician Face-to-Face Date: 04/28/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease 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 OT Eval Notes: PT Eval Notes:
 Physician Haney, Richard

SN Careplans | SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/02/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Richard Haney
7670 Quarterfield Rd,
Glen Burnie, MD 21061
PHONE: 410-508-7650 FAX: NPI: 1447665732

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 : 04/28/2026

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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SN WK1: 1 (05/02/26-05/02/26) ,WK2: 1 (05/03/26-05/09/26) ,WK3: 2 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/23/26) ,WK5: 1 (05/24/26-05/30/26) ,WK6: 1 (05/31/26-06/06/26) ,WK7: 1 (06/07/26-06/13/26)

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, 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 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: M2020 - Oral Med Management, meal preparation, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, limited endurance

PROCEDURES: cough/deep breathing exercises

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, * 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

PATIENT-STATED GOAL: TO LEARN THE FOODS TO EAT

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 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

PT Careplans

PT WK2: 1 (05/03/26-05/09/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT Goals

PATIENT-STATED GOAL: To be independent

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/02/2026

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Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK2: 1 (05/03/26-05/09/26) ,WK3: 1 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/23/26) ,WK5: 1 (05/24/26-05/30/26) ,WK6: 1 (05/31/26-06/06/26) ,WK7: 1 (06/07/26-06/13/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing

PROCEDURES: Medication review: Med list, To improve endurance: Improve activity tolerance, Therapeutic activity : Exe during the visit, cough/deep breathing exercises, incentive spirometer, home exercise program, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: to return to PLOF and improve

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 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 medication(s) purpose, schedule

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/02/2026