Home Health Certification and Plan of Care

Order ID: 1150/18483

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
99128763	05/02/2026	From: 05/02/2026 To: 06/30/2026	25417	217058

6. Patient's Name and Address

Joseph Polanka
4802 Wendel Ave,
Baltimore, MD 21206-
443-762-0314

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 07/29/1941 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	05/02/26

13. ICD	Other Pertinent Diagnoses	Date
I50.30	Unspecified diastolic (congestive) heart failure	05/02/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	05/02/26
N18.32	Chronic kidney disease stage 3b	05/02/26
D63.1	Anemia in chronic kidney disease	05/02/26
E11.65	Type 2 diabetes mellitus with hyperglycemia	05/02/26
I48.20	Chronic atrial fibrillation unspecified	05/02/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	05/02/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	05/02/26
I70.234	Athscl native art of right leg w ulcer of heel and midfoot	05/02/26
L97.418	Non-prs chronic ulcer of right heel/midft with oth severity	05/02/26
I70.244	Athscl native art of left leg w ulcer of heel and midfoot	05/02/26
L97.428	Non-prs chronic ulcer of left heel/midft with oth severity	05/02/26
I70.233	Athscl native arteries of right leg w ulceration of ankle	05/02/26
L97.318	Non-pressure chronic ulcer of right ankle with oth severity	05/02/26
J96.11	Chronic respiratory failure with hypoxia	05/02/26
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	05/02/26
E78.5	Hyperlipidemia unspecified	05/02/26
F43.21	Adjustment disorder with depressed mood	05/02/26
K59.00	Constipation unspecified	05/02/26
M10.9	Gout unspecified	05/02/26
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	05/02/26
Z79.4	Long term (current) use of insulin	05/02/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	05/02/26
Z79.891	Long term (current) use of opiate analgesic	05/02/26

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

ALLOPURINOL 100 mg/tablet / Give 2.5 tablet by mouth one time a day for Gout GOUT
Carvedilol - Carvedilol 12.5 mg tablet by mouth every 12 hours for HTN
Colchicine - Colchicine 0.6 mg capsule by mouth once a day every 24 hours as needed for Gout
Gabarone 100 mg tablet by mouth every 8 hours for Neuropathy
LACTULOSE 20gm/packet Oral Solution 20 GM/30ML / Give 30 ml by mouth at bedtime for constipation hold for loose stool CONSTIPATION
Pantoprazole Sodium - Pantoprazole Sodium Delayed Release 40 mg tablet by mouth two times a day for GERD GERD
Sennosides - Senna 8.6 mg/tablet / Give 2 tablet by mouth twice a day for constipation
SIMVASTATIN 40 mg 40 mg tablet by mouth at bedtime for HLD HLD
TORSEMIDE 20 mg 20 mg tablet by mouth two times a day for CHF CHF
Sertraline Hcl - Sertraline Hydrochloride 50 mg tablet by mouth one time a day for Depression DEPRESSION
Empagliflozin 10 mg tablet by mouth once a day for DM
Albuterol Sulfate - Albuterol Sulfate 0 Inhalation Nebulization Solution / 3 ml inhale by mouth every 6 hours as needed for Wheezing/SOB SOB
Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT / 1 inhalation by mouth twice a day for SOB/Wheezing Rinse and spit after use
Oxycodone-Acetaminophen 5-325 mg / 1 Tablet by mouth every 8 hours as needed for Pain PAIN
Flonase Allergy Relief - Fluticasone Propionate 50 MCG/ACT / 1 spray in both nostrils twice a day for allergy
Semaglutide Subcutaneous Solution Pen Injector 2 MG/3ML / Inject 0.5 mg; 16 UNITS subcutaneous at bedtime every Sun for DM
Insulin Glargine Subcutaneous Solution 100 UNIT/ML / Inject 16 units subcutaneous every 12 hours for DM

14. DME and Supplies:

diabetic supplies, urinary/catheter supplies, wheelchair, hospital bed, wound care supplies, commode, HOYER LIFT

15. Safety Measures:

wheelchair precautions, standard precautions, fall precautions, diabetic precautions, medication safety, transfer with assist, supervision at all times, sharps precautions, activity supervision

16. Nutrition:

cardiac diet, diabetic,

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Bowel/Bladder Incontinence, Ambulation

18.B. Activities Permitted

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

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required, 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

another facility/provider will be responsible for managing treatment
family/caregiver will be responsible for managing treatment
add discharge plan
add discharge plan

Homebound status: Due to diagnosis of Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney 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 was recently hospitalized with diagnoses of cardiomyopathy with newly reduced ejection fraction, hypertensive emergency, acute kidney injury (AKI), intermittent chest pain, and shortness of breath. Additional recent hospitalization diagnoses include transient hypoxemia, hyperglycemia, neuropathic lower extremity pain, and arterial heel and ankle wounds. Past medical history is significant for arterial vascular disease, congestive heart failure (CHF), type 2 diabetes mellitus, gout, hyperlipidemia, essential hypertension, atrial fibrillation, chronic kidney disease stage 3, morbid obesity, chronic pain, and urinary incontinence. 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 and treatment were also ordered. Spouse assists with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. During the skilled nursing assessment, the patient was alert and oriented 3, pleasant, and able to participate appropriately in the visit. Patient denied current shortness of breath or chest pain at the time of assessment. Lung sounds were clear throughout all lung fields with no acute respiratory distress noted. Patient reported good

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

Rita Mathur
4920 Campbell Blvd
White Marsh, MD 21236
PHONE: 410-933-7793 FAX: 14109337666 NPI: 1619076338

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 : 04/29/2026

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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appetite, and last bowel movement occurred today. Decreased endurance and activity tolerance were noted; however, patient was not utilizing an assistive device at the time of assessment. Medication reconciliation and review were completed, including discussion of medication names, dosages, frequencies, purposes, and pertinent side effects. Skilled nursing initiated disease process education related to cardiomyopathy, congestive heart failure management, and blood pressure monitoring. Patient and spouse were instructed on the importance of daily weight monitoring, adherence to prescribed medications, energy conservation techniques, and recognizing symptoms requiring physician or nursing notification, including worsening shortness of breath, chest pain, sudden weight gain, edema, dizziness, or uncontrolled blood pressure. Patient and spouse verbalized understanding of all teaching provided. Occupational therapy evaluation revealed significant functional decline following recent hospitalization. Patient is currently residing in a personal care home, though previously lived with her son in a single-family home with four steps to enter and a first-floor setup. Prior to hospitalization, the patient was reportedly independent with basic self-care tasks, functional transfers, and functional ambulation. Current assessment demonstrated decreased standing balance, standing tolerance, sitting balance, sitting tolerance, bilateral upper extremity strength, and overall activity tolerance, resulting in impaired performance with self-care activities, functional transfers, and ambulation tasks. These deficits significantly impact the patient's ability to safely perform daily activities and return to prior level of function. Skilled occupational therapy services are medically necessary to address strengthening, balance training, endurance, functional mobility, safety awareness, adaptive techniques, and self-care retraining to maximize independence and reduce risk of further decline or rehospitalization. Ongoing skilled nursing and therapy services remain indicated for cardiopulmonary monitoring, disease management education, medication management, wound monitoring, endurance training, fall prevention, and restoration of functional independence to the highest achievable level.
 Date of Order 05/02/2026 Orders Physician Face-to-Face Date: 04/29/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney 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:
 Physician Mathur, Rita

SN Careplans

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: 2 (05/17/26-05/23/26) ,WK5: 1 (05/24/26-05/30/26) ,WK6: 1 (05/31/26-06/06/26)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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:MOLST form on file

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M1745 - Behavioral Issues, D0160 - Depression, meal preparation, M2020 - Oral Med Management, dependent edema, M1400 - Dyspnea, M1033 - Exhaustion, M1620 - Bowel Incontinence, M1610 - Urinary Incontinence, muscle weakness, limited range of motion, limited strength, limited endurance, weak hand grips, #3 - Other - Other - RIGHT ANKLE - , #2 - Other - Other - LEFT ANKLE - , #1 - Other - Posterior Right Heel - , rough/scaly/cracked skin

PROCEDURES: physician-ordered wound care: #3 - Other - Other - RIGHT ANKLE -: SN/CG to cleanse with nss, apply medihoney and cover with dry dressing, secure with kerlix and tape .daily. cg to perform on the days nurse is not available, physician-ordered wound care: #2 - Other - Other - LEFT ANKLE -: SN/CG to cleanse with nss, apply medihoney and cover with dry dressing, secure with kerlix and tape .daily. cg to perform on the days nurse is not available, physician-ordered wound care: #1 - Other - Posterior Right Heel -: SN/CG to cleanse with nss, apply medihoney and cover with dry dressing, secure with kerlix and tape .daily. cg to perform on the days nurse is not available, cough/deep breathing exercises, coordinate/arrange caregiver support to prevent caregiver physical,

SN Goals

PATIENT-STATED GOAL: family has hopes of patient to walk again

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

patient/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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
* bowel incontinence management including dietary changes
* bowel training
* skin 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 self-administers medications as prescribed
* recalls 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	05/02/2026

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emotional and mental exhaustion, glucose testing via monitor: ALF TO MONITOR BLOOD GLUCOSE DAILY

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 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, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, 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, * bowel incontinence management including dietary changes bowel training skin 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

meal preparation is available to patient for all meals

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)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0170L1 - Walk 10 ft on Uneven Surface, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170I1 - Walk 10 Feet, GG0170P1 - Picking Up Object, GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170M1 - 1 - Step (curb), GG0170S1 - Wheel 150 feet, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Medication Review : Medication reviewed with caregiver with all medications in the home, wheelchair training, home exercise program: Bilateral UE strengthening of anterior deltoid, biceps, triceps and pectoral muscles, equipment training, work simplification/energy conservation, 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 - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 06. Independent, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, 1 - Step (curb) - 02. Substantial/maximal assistance, 12 Steps - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: Get out of bed

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

Toilet Transfer - 05. Setup or clean-up assistance

Car Transfer - 06. Independent

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

1 - Step (curb) - 02. Substantial/maximal assistance

12 Steps - 02. Substantial/maximal assistance

4 Steps - 02. Substantial/maximal assistance

Picking Up Object - 02. Substantial/maximal assistance

Walk 10 Feet - 02. Substantial/maximal assistance

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Walk 150 Feet - 02. Substantial/maximal assistance

Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 04. Supervision or touching assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

HHA Careplans

HHA WK3: 2 (05/10/26-05/16/26) ,WK4: 2 (05/17/26-05/23/26) ,WK5: 2 (05/24/26-05/30/26) ,WK6: 2 (05/31/26-06/06/26)

PROCEDURES: assist with bathing: Max A, assist with toilet transferring: Max A, assist with

HHA Goals

PATIENT-STATED GOAL: add patient-stated goal

GOALS

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/02/2026

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PROCEDURES: assist with bathing: Max A, assist with toilet transferring: Max A, assist with toileting hygiene: Max A, assist with transferring: Hover lift, assist with mobility: Wheelchair, assist with feeding/eating: Min A, assist with fall prevention: Max A bed mobility, assist with grooming: Max A, assist with lower body dressing: Max A, assist with upper body dressing: Max A

Signature of Physician:	Date
	PAGE 4 of 4
Optional Name/Signature of Nurse/Therapist:	Date
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