Home Health Certification and Plan of Care

Order ID: 1150/18463

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6Q78DV4RX64	05/04/2026	From: 05/04/2026 To: 07/02/2026	25444	217058

6. Patient's Name and Address

William Whitham
7705 Buckingham Nursery Dr.,
SEVERN, MD 21144-
443-822-4463

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 01/08/1949 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	05/04/26

13. ICD	Other Pertinent Diagnoses	Date
N18.31	Chronic kidney disease stage 3a	05/04/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/04/26
M35.00	Sjogren syndrome unspecified	05/04/26
K74.60	Unspecified cirrhosis of liver	05/04/26
G25.0	Essential tremor	05/04/26
E78.2	Mixed hyperlipidemia	05/04/26
I73.9	Peripheral vascular disease unspecified	05/04/26
G25.81	Restless legs syndrome	05/04/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	05/04/26
Z85.818	Prsnl hx of malig neoplm of site of lip oral cav & pharynx	05/04/26

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

AMLODIPINE 5 mg / 1 Tablet by mouth daily Commonly known as: NORVASC blood pressure
ACETAMINOPHEN 500 mg / 1 Tablet by mouth every 6 hours as needed for Pain MODERATE Pain (or if patient requests it for severe pain) or MILD Pain (or if patient requests it for moderate or severe pain). Commonly known as: TYLENOL
Clopidogrel - Clopidogrel 75 mg 75mg; 1 tab by mouth once a day cva prophylactic
Cevimeline Hydrochloride - Cevimeline Hydrochloride 30mg; 1 cap by mouth three times a day as needed for dry eyes or dry mouth
Asa 81 Mg - Aspirin 81mg; 1tab by mouth once a day prophylaxis

14. DME and Supplies:

None of the above

15. Safety Measures:

standard precautions, fall precautions, bleeding precautions, medication safety, ambulates with assistance, transfer with assist, supervision at all times, anticoagulant precautions

16. Nutrition:

cardiac diet,

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Exercises Prescribed,

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: 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

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive chronic kidney disease with 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:

Start of care skilled nursing and physical therapy assessments were completed for a 77-year-old male recently admitted to BWMC on 11/26/26 with diagnoses of transient ischemic attack (TIA), altered mental status, and hypertension. Per discharge paperwork, the patient experienced an in-home cerebrovascular accident (CVA). Past medical history is significant for Sjogren's syndrome, liver cirrhosis, encephalopathy, and hearing impairment (HOH). The patient resides with his spouse, Carol, in a large three-story home with two steps required to enter; however, since hospitalization and CVA, the patient has remained primarily on the first floor due to decreased mobility and safety concerns. The spouse remains with the patient at all times and assists with all ADLs and IADLs as needed, expressing concern regarding leaving the patient unattended. Prior to the CVA, the patient was independent and working full-time as a technical support engineer. No falls were reported within the last year. Upon assessment, the patient was alert and oriented x3. He reported right-sided low back pain but denied shortness of breath. Lung sounds were diminished bilaterally. The patient reported a fair appetite, with last bowel movement occurring during hospitalization. The patient was noted to ambulate without an assistive device; however, gait was slow and unsteady, placing him at increased risk for falls. Skilled nursing reviewed all medications with the patient and spouse, including medication names, dosages, frequencies, purposes, and pertinent side effects. Education was provided regarding signs and symptoms of bleeding due to current Plavix therapy, and the spouse verbalized understanding of all instructions provided. Physical therapy evaluation revealed deficits including right-sided low back pain, decreased bilateral lower extremity strength, impaired balance, decreased functional mobility, difficulty with transfers and stair negotiation, unsteady gait, decreased safety awareness, and increased fall risk. The patient currently requires standby assistance (SBA) for safe transfers and ambulation on level surfaces. During transfer training, the patient was instructed on proper hand and foot placement, forward weight shifting, and reaching back prior to sitting to improve safety and reduce fall risk. Gait training was completed without an assistive device, with verbal cueing provided to improve bilateral step height, step length, and overall gait safety. Standardized balance and gait assessments, including the Tinetti and Timed Up and Go (TUG) assessments, were performed to evaluate mobility and fall risk. Extensive education was provided regarding home safety, fall prevention strategies, environmental modifications, and risk factors contributing to falls, utilizing the patient handbook as a resource. The patient was instructed on the importance of daily ambulation to improve circulation, endurance, and prevent complications associated with immobility. A walking program was initiated, recommending short walks throughout the home every 1-2 hours and longer walks beginning at 3-5 minutes with gradual progression as tolerated. Additional instruction was provided regarding use of heat therapy to the low back for 20 minutes at a time with appropriate skin protection and skin checks every five minutes. Pain management education included taking pain medication at the onset of pain, monitoring for side effects such as dizziness and constipation, and notifying EMS or the physician for chest pain, uncontrolled pain, or shortness of breath. The patient was also advised to take pain medication approximately one hour prior to physical therapy visits to optimize participation. The patient verbalized understanding through teach-back. The patient is considered homebound secondary to CVA-related weakness, impaired balance, decreased endurance, and high fall risk, requiring human assistance and the intermittent use of an assistive device such as a cane or walker to safely leave the home. Leaving the home requires considerable effort and presents a safety risk. Skilled nursing services are planned at a frequency of 1 visit weekly for 12 weeks, followed by 2 visits weekly for 1 week, then 1 visit weekly for 6 weeks. Skilled home physical therapy services are planned beginning 5/5/26 at a frequency of 2 visits weekly for 2 weeks, then 1 visit weekly for 5 weeks to address strength, mobility, balance, transfer training, gait safety, stair negotiation, pain management, and restoration of functional independence within the home environment. Patient and spouse are in agreement with the plan of care.
 Date of Order 05/04/2026 Orders Physician Face-to-Face Date: 04/30/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat due to Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease,

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/04/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Bhawna Bahethi
1600 Crain Highway
Glen Burnie, MD 21061
PHONE: 4107668911 FAX: 14107668977 NPI: 1629150586

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 : 04/30/2026

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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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 PT Eval Notes:
 Physician Bahethi, Bhawna

SN Careplans

SN WK1: 1 (05/04/26-05/09/26) ,WK2: 2 (05/10/26-05/16/26) ,WK3: 2 (05/17/26-05/23/26) ,WK4: 1 (05/24/26-05/30/26) ,WK5: 1 (05/31/26-06/06/26) ,WK6: 1 (06/07/26-06/13/26) ,WK7: 1 (06/14/26-06/20/26) ,WK8: 1 (06/21/26-06/27/26) ,WK9: 1 (06/28/26-07/01/26)

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: 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 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 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:Not Received

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, lung sounds not clear, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, limited endurance, balance deficit, B0200 - Hearing Deficit, Pain Effect on Sleep, Pain Interference with ADLs, pallor

PROCEDURES: coordinate/arrange home modifications for hearing impaired, i.e. alarms

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, * 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 hearing-impaired including installing special fire-detector/CO2 alarms, 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

SN Goals

PATIENT-STATED GOAL: TO GET BETTER

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
* 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

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/04/2026

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PT WK1: 2 (05/04/26-05/09/26) ,WK2: 2 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26) ,WK4: 1 (05/24/26-05/30/26) ,WK5: 1 (05/31/26-06/06/26) ,WK6: 1 (06/07/26-06/13/26) ,WK7: 1 (06/14/26-06/20/26)

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

PROCEDURES: home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., therapeutic modalities: Apply heat to low back x 20 minutes with necessary barrier and skin assessments q 5 minutes., work simplification/energy conservation, dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., 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, * 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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: I want to be able to improve my balance

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
05/04/2026