

Home Health Certification and Plan of Care				Order ID: 1150/18747	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
24230962		05/13/2026		From: 05/13/2026 To: 07/11/2026	
4. Medical Record No.		5. Provider No.			
17818		217058			
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Thomas Howell 119 Riverthorn Rd, Middle River, MD 21220- 443-559-9961			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
10/22/1953			Male		
11. ICD			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
11.0 Principal Diagnosis			Extra Strength Tylenol - Acetaminophen 650mg by mouth twice a day Pain		
Hypertensive heart disease with heart failure			Bupropion Hydrobromide - Bupropion Hydrobromide 150 by mouth once a day Depression and anxiety		
Date			Digitek - Digoxin 125 by mouth at bedtime		
05/13/26			Dabigatran Etexilate - Dabigatran Etexilate 150 by mouth twice a day		
13. ICD			Escitalopram - Escitalopram Oxalate 20mg by mouth in the morning		
Other Pertinent Diagnoses			Famotidine - Famotidine 20 mg by mouth twice a day		
Date			Vitamin D - Ergocalciferol 125 mcg by mouth in the morning		
05/13/26			Pravachol - Pravastatin Sodium 40 mg by mouth in the evening		
150.30 Unspecified diastolic (congestive) heart failure			Pantoprazole - Pantoprazole Sodium 40 mg by mouth twice a day		
E11.319 Type 2 diabetes w unsp diabetic rtnop w/o macular edema			Memantine Hydrochloride - Memantine Hydrochloride 10 mg by mouth twice a day		
L24.9 Irritant contact dermatitis unspecified cause			Colace - Docusate Sodium 100mg by mouth twice a day		
I48.91 Unspecified atrial fibrillation			Cpap - Cpap 2 inhalant at bedtime		
E03.8 Other specified hypothyroidism					
F02.80 Dem in oth dis classd elswhrunsp sevw/o beh/psych/mood/anx					
G47.33 Obstructive sleep apnea (adult) (pediatric)					
D64.9 Anemia unspecified					
E11.40 Type 2 diabetes mellitus with diabetic neuropathy unsp					
R13.10 Dysphagia unspecified					
F41.9 Anxiety disorder unspecified					
F32.A Depression unspecified					
K21.9 Gastro-esophageal reflux disease without esophagitis					
Z79.01 Long term (current) use of anticoagulants					
Z79.4 Long term (current) use of insulin					
Z86.14 Personal history of methicillin resis staph infection					
14. DME and Supplies:			15. Safety Measures:		
wheelchair, diabetic supplies, bath bench, grab bars, commode, wound care supplies, hospital bed			wheelchair precautions, standard precautions, knee precautions, fall precautions, diabetic precautions, medication safety, bedrails up while in bed, anticoagulant precautions, bathroom safety		
16. Nutrition:			17. Allergies:		
cardiac diet, diabetic			no known allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
Endurance, Ambulation			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:			22.B. Discharge Plans		
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.			SN: patient will be responsible for managing treatment PT and OT: family/careg		
Homebound status: Due to diagnosis of Hypertensive heart disease with heart failure, 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: <p class="MsoNoSpacing">The patient is a 72-year-old male with a significant past medical history including congestive heart failure, acute encephalopathy, delirium, respiratory failure requiring intubation, hypertensive heart disease, diabetes, hypothyroidism, anemia, neuropathy, glaucoma, depression, sleep apnea, and multiple MRSA/staphylococcal infections complicated by tissue, bone, and spinal epidural involvement requiring thoracic laminectomy and prolonged IV antibiotic therapy. He is status post left total knee arthroplasty complicated by MRSA bacteremia, with hardware removal, spacer placement, and treatment with IV Ceftaroline transitioned to Daptomycin. The surgical incision is well approximated with three Steri-Strips intact and left open to air. The patient is alert and oriented x4, denies shortness of breath, and is currently bedbound pending physical therapy evaluation due to severe bilateral lower extremity weakness, trunk weakness, poor flexibility, impaired balance, and significant functional decline. He resides with his wife and niece caregiver in a two-story townhome and currently requires extensive assistance with ADLs, transfers, and mobility. Recommendations have been made for durable medical equipment including a trapeze, hover lift, walker, and wheelchair. The patient also presents with bilateral buttock wounds; wound care orders approved by Dr. Jerome Chambers include cleansing with normal saline, applying Aquacel alginate, and covering with bordered foam dressings daily or as needed if soiled. Additional laboratory orders requested near 6/11/26 include CBC without differential, Chem 7, Digoxin level, Hemoglobin A1C, and TSH with reflex to free T4. Skilled nursing, home health aide, physical therapy, and occupational therapy services are recommended to address wound management, debility, decreased strength and endurance, impaired mobility, and reduced independence with self-care tasks, with fair rehabilitation potential noted.</o:p></o:p></p> <p class="MsoNoSpacing"><o:p> </o:p></p> <p class="MsoNoSpacing">Date of Order<o:p></o:p></p> <p class="MsoNoSpacing">05/13/2026 Order<o:p></o:p></p> <p class="MsoNoSpacing">Physician Face-to-Face Date: 05/09/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Hypertensive heart disease with heart failure Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p></p> <p class="MsoNoSpacing"> 1 - SOC - SN Notes: PT Eval Notes: OT Eval Notes:<o:p></o:p></p> <p class="MsoNoSpacing">Physician: Chambers, Jerome</p>					
SN Careplans			SN Goals		
23. Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT		
Electronically Signed by Messick, Charles RN on 05/13/2026					
24. Physician's Name and Address			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.		
Jerome Chambers 4920 Campbell Blvd White Marsh, MD 21236 PHONE: 14109337600 FAX: NPI: 1053978189			F2F date : 05/09/2026		
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 (05/13/26-05/16/26) ,WK2: 1 (05/17/26-05/23/26) ,WK3: 1 (05/24/26-05/30/26) ,WK4: 1 (05/31/26-06/06/26) ,WK5: 1 (06/07/26-06/13/26) ,WK6: 1 (06/14/26-06/20/26) ,WK7: 1 (06/21/26-06/27/26) ,WK8: 1 (06/28/26-07/04/26)

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, 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, 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, muscle weakness, weak hand grips, balance deficit, Pain Interference with ADLs, skin breakdown r/t incontinence, #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Buttock - , #2 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Left Buttock - , #3 - Observable Surgical Wound - Anterior Left Knee - left knee surgical site

PROCEDURES: physician-ordered wound care: #3 - Observable Surgical Wound - Anterior Left Knee - left knee surgical site: Left Knee surgical site: leave open to air and allow the Steri strips to fall off on its own., physician-ordered wound care: #2 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Left Buttock -: The verbal order was given by Dr. Jerome Chambers to cleanse the right and left buttocks with Normal saline, apply Aquacel alginate, and cover with a bordered foam dressing. Change dressing daily or PRN if soiled., physician-ordered wound care: #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Buttock -: The verbal order was given by Dr. Jerome Chambers to cleanse the right and left buttocks with Normal saline, apply Aquacel alginate, and cover with a bordered foam dressing. Change dressing daily or PRN if soiled., cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, venipuncture: On 6/4/26, draw labs for CBC no differential, Chem 7 non fasting, Hemoglobin A1C, Digoxin level, TSH with reflex to Free T4.

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound

PATIENT-STATED GOAL: For wounds to heal

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 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 achieve wound healing including cleaning and dressing wound
- * position changes
- * skin care
- * diet modification
- * record wound measurements
- * recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed

- * 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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/13/2026

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measurements, 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				
PT Careplans		PT Goals		
PT WK1: 1 (05/13/26-05/16/26) ,WK2: 2 (05/17/26-05/23/26) ,WK3: 1 (05/24/26-05/30/26) ,WK4: 1 (05/31/26-06/06/26) ,WK5: 1 (06/07/26-06/13/26) ,WK6: 1 (06/14/26-06/20/26) ,WK7: 1 (06/21/26-06/27/26) ,WK8: 1 (06/28/26-07/04/26) ,WK9: 1 (07/05/26-07/11/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, GG0170F1 - Toilet Transfer, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer PROCEDURES: Bed mobility : Focus on rolling amd side<>sit transfer techniques, Sitting balance : Focus on achieving and maintaining static and dynamic balance sitting with bil UE support, cough/deep breathing exercises, wheelchair training, home exercise program: Le and trunk stretching all planes to improve mobility, supine heelslides, hip abduction add, saq, slr, qs, GS, KTC AND Ltr stretching, seated tes as tolerated, 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, * 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 - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 03. Partial/moderate assistance, Wheel 50 ft w 2 Turns - 06. Independent, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 03. Partial/moderate assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 05. Setup or clean-up assistance		PATIENT-STATED GOAL: To be able to get out of bed I to a chair, improve my strength GOALS Sit to Stand - 04. Supervision or touching assistance Chair to Bed to Chair - 04. Supervision or touching assistance Toilet Transfer - 03. Partial/moderate assistance Wheel 50 ft w 2 Turns - 06. Independent Toileting Hygiene - 03. Partial/moderate assistance Shower/Bathe Self - 03. Partial/moderate assistance Upper Body Dressing - 05. Setup or clean-up assistance Lower Body Dressing - 03. Partial/moderate assistance Don/Doff Footwear - 03. Partial/moderate 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 Oral Hygiene - 05. Setup or clean-up assistance Eating - 05. Setup or clean-up assistance		
OT Careplans		OT Goals		
OT WK2: 1 (05/17/26-05/23/26) ,WK3: 1 (05/24/26-05/30/26) ,WK4: 1 (05/31/26-06/06/26) ,WK5: 1 (06/07/26-06/13/26) ,WK6: 1 (06/14/26-06/20/26) ,WK7: 1 (06/21/26-06/27/26) 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 : Medication reviewed with patient and caregiver with all medications in the home, cough/deep breathing exercises, incentive spirometer, home exercise program: Bilateral UE strengthening of anterior deltoid, biceps, triceps, work simplification/energy conservation, transfers training: Skilled OT 1x5, assist with bathing: Skilled OT 1x5, assist with toilet transferring: Skilled OT 1x5, assist with transferring: Skilled OT 1x5, assist with lower body dressing: Skilled OT 1x5, assist with upper body dressing: Skilled OT 1x5 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent		PATIENT-STATED GOAL: Walk better GOALS Shower/Bathe Self - 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 Oral Hygiene - 06. Independent Toileting Hygiene - 05. Setup or clean-up assistance Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent		
HHA Careplans		HHA Goals		
HHA WK2: 1 (05/17/26-05/23/26) ,WK3: 2 (05/24/26-05/30/26) ,WK4: 2 (05/31/26-06/06/26) ,WK5: 2 (06/07/26-06/13/26) ,WK6: 2 (06/14/26-06/20/26) PROCEDURES: assist with bathing: Max A, assist with toilet transferring: Max A, assist with toileting hygiene: Max A, assist with transferring: Max A, assist with mobility: Bed mobility Max A, assist with feeding/eating: Max A, assist with grooming: Max A, assist with lower body dressing: Max A, assist with lower body dressing: Max A, assist with upper body dressing: Max A				
Signature of Physician:		Date		
		PAGE 3 of 3		
Optional Name/Signature of Nurse/Therapist:		Date		
Electronically Signed by Messick, Charles RN		05/13/2026		