Home Health Certification and Plan of Care

Order ID: 1150/18818

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
87296463	05/18/2026	From: 05/18/2026 To: 07/16/2026	25818	217058

6. Patient's Name and Address
William Mcilwain
6221 The Alemeda,
BALTIMORE, MD 21239
443-825-0029

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 09/05/1953 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
E11.621	Type 2 diabetes mellitus with foot ulcer	05/18/26

13. ICD	Other Pertinent Diagnoses	Date
L97.418	Non-prs chronic ulcer of right heel/midft with oth severity	05/18/26
I10.	Essential (primary) hypertension	05/18/26
E78.5	Hyperlipidemia unspecified	05/18/26
D64.9	Anemia unspecified	05/18/26
M48.02	Spinal stenosis cervical region	05/18/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	05/18/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	05/18/26
Z86.19	Personal history of other infectious and parasitic diseases	05/18/26

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

Metformin Hcl - Metformin Hydrochloride Extended Release 24 hour 500 mg / 1 Tablet by mouth at bedtime related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9)
Atorvastatin - Atorvastatin Calcium 40mg by mouth at bedtime HLD
Amilodipine - Amlodipine Besylate 10mg by mouth in the morning HTN
Lisinopril - Lisinopril 10 mg 10mg by mouth once a day HTN
Aspirin 81Mg - Aspirin 81mg by mouth once a day

14. DME and Supplies:
cane

15. Safety Measures:
supervision at all times, standard precautions, wheelchair precautions, walker precautions, fall precautions, anticoagulant precautions, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:
low cholesterol, low sodium, diabetic

17. Allergies:
penicillin

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
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: No

20. Prognosis: good

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

Homebound status: Due to diagnosis of Type 2 diabetes mellitus with foot ulcer, 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:

Patient is a 72-year-old male admitted to home health services following recent hospitalization and surgical intervention related to a right lower extremity Achilles injury complicated by abscess formation requiring surgical debridement and skin graft placement. Start of care visit completed, and all consents were reviewed and signed by the patient. The patient is considered homebound due to significant effort required to leave the home secondary to impaired mobility, decreased endurance, need for assistive devices, and requirement for one-person assistance for safe ambulation. Ambulatory status currently requires use of a cane with contact guard assistance, making leaving the home taxing and unsafe without caregiver support. Past medical history is significant for type 2 diabetes mellitus with neuropathy, right heel and midfoot ulcer, reversible ischemic neurologic deficit syndrome, anemia, history of septic shock, hypertension, hyperlipidemia, cervical spinal stenosis, transient ischemic attack, and decreased vision in the right eye. Patient resides with spouse in a single-family home and was previously independent with self-care tasks, functional transfers, and ambulation prior to recent hospitalization and decline in condition. On assessment, patient was alert and oriented x3-4 and denied acute distress. Patient reported bowel movement occurred on the day of assessment. Medication reconciliation was completed with both patient and caregiver, including review of prescriptions provided upon discharge from the skilled nursing facility. Current medications include cephalexin 500 mg orally twice daily for 10 days for infection prevention and oxycodone every 6 hours as needed for post-surgical pain management. Patient denied pain at the surgical site during assessment. No abnormal lung sounds were noted, and no abnormal bleeding was reported. Follow-up appointments were reviewed with patient and caregiver, including podiatry/wound care appointment scheduled for 05/20/2026 at 11:30 AM and plastic surgery follow-up scheduled for 06/18/2026 at 10:30 AM. Assessment of the right lower leg surgical wound revealed a wound measuring 15.5 cm x 6.5 cm x 0.4 cm. Wound bed appeared flesh-colored with areas of yellow tissue present. No odor, active drainage, or abnormal bleeding was noted during assessment. Wound care orders were reviewed and performed during the visit. Wound cleansed with wound cleanser, xeroform wound gel applied, followed by gauze dressing and Kerlix wrap secured with tape. Dressing change was completed by skilled nurse with caregiver/spouse present for observation and education regarding wound care management, infection prevention, and signs/symptoms requiring prompt reporting. A wound photograph was attempted but did not upload successfully through the tablet system. Physical therapy evaluation noted that the patient was recently cleared by the physician to begin weight-bearing on the right lower extremity while wearing a protective boot. Patient ambulates approximately 30 feet on indoor surfaces using a cane with contact guard assistance and performs 14 interior stairs with use of railing and verbal cueing for safety and technique. Patient also completed 7 exterior steps with cane and minimal assistance while spouse observed. Bed mobility and transfers to bed, chair, and toilet require supervision, while car transfers require contact guard assistance. Tinetti balance and gait assessment score was 12/28, indicating high fall risk. Patient tolerated therapeutic exercises including 10 repetitions each of supine hip flexion, bridging, straight leg raises, hip abduction, knee extension, and ankle pumps. Patient demonstrates generalized weakness, impaired balance, decreased endurance, and reduced mobility requiring continued skilled physical therapy intervention to improve strength, gait safety, transfer ability, and functional independence while reducing fall risk. Occupational therapy evaluation further identified deficits in standing balance, standing tolerance, bilateral upper extremity strength, activity tolerance, functional transfers, and self-care performance. These impairments have significantly impacted the patient's ability to safely perform activities of daily living and functional ambulation at prior level of function. Skilled OT services are recommended to address deficits, improve safety and independence with ADLs, enhance functional mobility, and support return to prior level of functioning. Skilled nursing frequency ordered for two visits weekly for three weeks, then once weekly until the end of the episode. Physical therapy and occupational therapy services also ordered for continued rehabilitation, strengthening, mobility training, safety education, fall prevention, wound healing support, and caregiver education.
 Date of Order 05/18/2026 Orders Physician Face-to-Face Date: 05/11/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Type 2 diabetes mellitus with foot ulcer 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: OT Eval Notes:
 Physician Watts, Charlotte

SN Careplans | SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/18/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Charlotte Watts
2391 Greenspring Dr
Timonium, MD 21093
PHONE: 4103395500 FAX: 14103395960 NPI: 1336481951

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 : 05/11/2026

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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6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
William Mcilwain 6221 The Alemeda, BALTIMORE, MD 21239 443-825-0029	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

SN WK1: 1 (05/18/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK3: 2 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK6: 1 (06/21/26-06/27/26) ,WK7: 1 (06/28/26-07/04/26) ,WK8: 1 (07/05/26-07/11/26)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 months, 7. Currently taking 5 or more medications

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; 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 ; 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.

Right lower leg wound cleanse wound with wound cleanser apply xeroform wound gel, cover with gauze and wrap with kerlix secure with tape. Wound size 15.5x6.5x0.4cm, wound bed is flesh/ yellow/
Advance Directive:No

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, abnormal blood pressure, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal BS < 70/140 > mg/dL, constipation, limited range of motion, limited endurance, muscle weakness, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit, balance deficit, open sores/lesions, red/tender pressure points, #1 - Observable Surgical Wound - Anterior Right Ankle -

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Right Ankle -: cleanse wound with wound cleanser apply xeroform wound gel, cover with gauze and wrap with kerlix secure with tape. Wound size 15.5x6.5x0.4cm, wound bed is flesh/ yellow/, cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: cleanse wound with wound cleanser apply xeroform wound gel, cover with gauze and wrap with kerlix secure with tape. Wound size 15.5x6.5x0.4cm, wound bed is flesh/ yellow/, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

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 achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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 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

PATIENT-STATED GOAL: For wound to resolve

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 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
* 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 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	05/18/2026

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PT Careplans

PT WK1: 1 (05/18/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK6: 1 (06/21/26-06/27/26) ,WK7: 1 (06/28/26-07/04/26) ,WK8: 1 (07/05/26-07/11/26), WK9: 1 (07/12/2026 - 07/16/2026)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface

PROCEDURES: Family training with wife: For steps and gait, 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, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: Walking independently with the walker until I get my boot taken off

GOALS
Toilet Transfer - 06. Independent

Sit to Stand - 05. Setup or clean-up assistance

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

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

OT Careplans

OT WK1: 1 (05/18/26-05/23/26)

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 with all medications in the home, home exercise program: Bilateral UE strengthening of deltoid, biceps, triceps and pectoral muscles, therapeutic exercises: Skilled OT 1x5 wks, equipment training, work simplification/energy conservation, transfers training: Skilled OT 1x5 wks, assist with bathing: Skilled OT 1x5 wks, assist with toileting hygiene: Skilled OT 1x5 wks, assist with lower body dressing: Skilled OT 1x5 wks, assist with upper body dressing: Skilled OT 1x5 wks

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 - 06. Independent, 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

OT Goals

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 - 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	05/18/2026