Home Health Certification and Plan of Care

Order ID: 1150/18877

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
49603327800	05/13/2026	From: 05/13/2026 To: 07/11/2026	25359	217058

6. Patient's Name and Address
Ivan Bridglal
5936 St Marys St,
GWYNN OAK, MD 21207-
443-226-8283

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 09/17/1941 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	05/13/26

13. ICD	Other Pertinent Diagnoses	Date
F03.94	Unspecified dementia unspecified severity with anxiety	05/13/26
F03.93	Unsp dementia unspecified severity with mood disturb	05/13/26
F32.A	Depression unspecified	05/13/26
E78.5	Hyperlipidemia unspecified	05/13/26
G47.00	Insomnia unspecified	05/13/26
F22.	Delusional disorders	05/13/26
H54.62	Unqualified visual loss left eye normal vision right eye	05/13/26
D64.9	Anemia unspecified	05/13/26
R33.9	Retention of urine unspecified	05/13/26
Z46.6	Encounter for fitting and adjustment of urinary device	05/13/26
Z79.899	Other long term (current) drug therapy	05/13/26
Z79.4	Long term (current) use of insulin	05/13/26
Z87.440	Personal history of urinary (tract) infections	05/13/26
Z91.81	History of falling	05/13/26

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

Depakote - Divalproex Sodium 125 mg Delayed Release 125 mg/capsule / Give 2 capsule by mouth two times a day for Hypomania
Lexapro - Escitalopram Oxalate 10 mg 10 mg / 1 Tablet by mouth one time a day for depression and anxiety
Pravastatin Sodium - Pravastatin Sodium 80 mg / 1 Tablet by mouth at bedtime for Hyperlipidemia
Trazodone Hydrochloride - Trazodone Hydrochloride 50 mg / 1 Tablet by mouth at bedtime for Insomnia
SEROQUEL 25 mg / 1 Tablet orally two times a day related to VASCULAR DEMENTIA, UNSPECIFIED SEVERITY, WITH AGITATION (F01.511)
Humalog Kwikpen - Insulin Lispro Recombinant 100 UNIT/ML subcutaneously three times a day Inject as per sliding scale: if 150 - 200 = 2; 201 - 300 = 4; 301 - 350 = 6; 351 - 400 = 8, for Diabetes Mellitus
Lantus Solostar - Insulin Glargine Recombinant 100 UNIT/ML / Inject 10 unit subcutaneously at bedtime for DM

14. DME and Supplies:
cane, rolling walker, , diabetic supplies, wheelchair

15. Safety Measures:
walker precautions, wheelchair precautions, supervision at all times, standard precautions, medication safety, medical alert/lifeline, infectious material management, fall precautions, bedrails up while in bed, activity supervision

16. Nutrition:
regular, pureed

17. Allergies:
no known allergies

18.A. Functional Limitations
Bowel/Bladder Incontinence, Ambulation, Speech, Endurance

18.B. Activities Permitted
Up As Tolerated, Cane, Wheelchair

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: 4. Constantly, SOCIAL ISOLATION: 8. Patient unable to respond, 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!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, 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: 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
SN: patient to receive home care indefinately PT and OT: family/caregiver will b

Homebound status: Due to diagnosis of Type 2 diabetes mellitus with diabetic polyneuropathy, 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 an 84-year-old male with a medical history significant for Type 2 diabetes mellitus, dementia, hyperlipidemia, anemia, BPH, and urinary retention with an indwelling Foley catheter. The patient was recently hospitalized following multiple falls and is currently bedbound since returning home. During assessment, the patient was not fully alert but was able to follow simple commands intermittently and occasionally responded by verbalizing "no" or pushing away during care. The patient requires assistance with turning, repositioning, and all ADLs, with his spouse serving as primary caregiver and present throughout the assessment. Prior to hospitalization, the patient ambulated short distances with a single-point cane and utilized a stair lift daily, while requiring assistance with medication management. The patient currently has an 18 Fr Foley catheter with a 30 cc balloon draining clear yellow urine; however, foul odor and reported yellow drainage were noted at the insertion site, and the RN will notify the urologist and PCP for further evaluation and recommendations. Skin remains intact. PT evaluation revealed decreased strength and impaired functional mobility secondary to cognitive deficits and deconditioning. The patient was able to participate minimally in bed mobility and sit at the edge of the bed with support. Wheelchair safety and setup education were provided to the caregiver, and transfer training was initiated, with the patient completing sit-pivot transfers with maximum assistance. Skilled nursing visits were scheduled every two weeks for Foley catheter management and ongoing assessment; however, discipline discharge was completed per caregiver request due to transition to hospice care.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 05/13/2026
 Order<o:p></o:p> Physician Face-to-Face Date: 05/07/2026
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Type 2 diabetes mellitus with diabetic polyneuropathy
 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>
 1 - SOC - SN Notes:
 PT Eval Notes:<o:p></o:p> Physician: Baffoe-Bonnie, Edna

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/13/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Edna Baffoe-Bonnie
7900 Oak Point Ct
Pasadena, MD 21122
PHONE: 4438701237 FAX: 14432961684 NPI: 1982117388

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 : 05/07/2026

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)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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

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:Do not resuscitate (DNR) orders

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, D0160 - Depression, M1700 - Cognition, M1720 - Anxiety, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal BS < 70/140 > mg/dL, cough/gag/pain chew/swallow, M1620 - Bowel Incontinence, foul-smelling urine, M1610 - Urinary Catheter, urine retention, muscle weakness, limited range of motion, limited endurance, B1000 - Vision Deficit, impaired speech, sensitivity to sounds & light, daytime fatigue, balance deficit, bad breath

PROCEDURES: Lab specimen- Urine culture : Per Chesapeake urology, sent on May 18, rn to take urine for culture after catheter change., cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor, monitor intake & output, catheter change, care & irrigation: Coude tip catheter 18french 10cc balloon, change catheter every 4 weeks., teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver*, 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, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, 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)

PATIENT-STATED GOAL: Patient cannot speak

GOALS
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
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient/caregiver recalls
* urinary catheter management including how to flush catheter
* change and wash drainage bags
* prevent infection including proper handwashing
* positioning of catheter
* 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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

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

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

Date
05/13/2026

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purpose, schedule, patient's transportation needs are met, 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

PT Careplans

PT WK1: 1 (05/13/26-05/16/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, wheelchair training, home exercise program: Initial HEP: sitting in wc with knees flexed at least 10 minutes daily. Add BLE therex of knee ext, hip flex, hip abd if pt is able to follow directions. Upgrade as tolerated, transfers training

PT Goals

PATIENT-STATED GOAL: To be able to transfer with less help

OT Careplans

OT WK2: 1 (05/17/26-05/23/26)

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

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 - 01. Dependent, Toileting Hygiene - 01. Dependent, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 01. Dependent, Lower Body Dressing - 01. Dependent, Don/Doff Footwear - 01. Dependent, Eating - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: OT eval only

GOALS
Shower/Bathe Self - 02. Substantial/maximal 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 - 01. Dependent

Toileting Hygiene - 01. Dependent

Upper Body Dressing - 01. Dependent

Lower Body Dressing - 01. Dependent

Don/Doff Footwear - 01. Dependent

Eating - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/13/2026