Home Health Certification and Plan of Care

Order ID: 1150/19399

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6R97WM4WP59	06/01/2026	From: 06/01/2026 To: 07/30/2026	26221	217058

6. Patient's Name and Address

Ernest Holmboe
7815 Oxford Dr,
Elkridge, MD 21075-
443-936-9477

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 03/09/1938 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I11.0	Hypertensive heart disease with heart failure	06/01/26

13. ICD	Other Pertinent Diagnoses	Date
I50.33	Acute on chronic diastolic (congestive) heart failure	06/01/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/01/26
N18.30	Chronic kidney disease stage 3 unspecified	06/01/26
L89.620	Pressure ulcer of left heel unstageable	06/01/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	06/01/26
J90.	Pleural effusion not elsewhere classified	06/01/26
N13.30	Unspecified hydronephrosis	06/01/26
I48.0	Paroxysmal atrial fibrillation	06/01/26
N13.9	Obstructive and reflux uropathy unspecified	06/01/26
N20.0	Calculus of kidney	06/01/26
K57.90	Dvrtclos of intest part unsp w/o perf or abscess w/o bleed	06/01/26
E78.5	Hyperlipidemia unspecified	06/01/26
E03.9	Hypothyroidism unspecified	06/01/26
R33.9	Retention of urine unspecified	06/01/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	06/01/26
Z79.4	Long term (current) use of insulin	06/01/26
Z79.01	Long term (current) use of anticoagulants	06/01/26
Z46.6	Encounter for fitting and adjustment of urinary device	06/01/26
Z95.0	Presence of cardiac pacemaker	06/01/26
Z95.5	Presence of coronary angioplasty implant and graft	06/01/26
Z85.46	Personal history of malignant neoplasm of prostate	06/01/26
Z87.440	Personal history of urinary (tract) infections	06/01/26
Z91.81	History of falling	06/01/26

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

AMIODARONE 200 mg / 1 Tablet by mouth in the morning for Paroxysmal Atrial Fibrillation
ELIQUIS 2.5 mg / 1 Tablet by mouth every morning and at bedtime for Paroxysmal Atrial Fibrillation
ENTRESTO 24-26 mg / 1 Tablet by mouth two times a day for CHF
Lasix - Furosemide 40 mg 40 mg / 1 Tablet by mouth two times a day for CHF HOLD FOR SBP < 90
Therapeutic M - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 Tablet by mouth in the morning for VITAMIN SUPPLEMENT
OMEGA-3 500 mg/capsule / Give 2 capsule by mouth in the morning for Supplement
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 2000 UNIT / 1 Tablet by mouth in the morning for VITAMIN D DEFICIENCY
Senokot S - Senna 8.6-50 mg / 1 Tablet by mouth in the morning for Bowel Regimen
Synthroid - Levothyroxine Sodium 50 mcg / 1 Tablet by mouth one time a day for Hypothyroidism BEFORE BREAKFAST
Colesevelam HCl 625 mg/tablet / Give 2 tablet by mouth twice a day for HYPERLIPIDEMIA
Vitamin B + C Complex Tablet (B Complex-C) Give 1 tablet by mouth in the morning for VITAMIN SUPPLEMENT
Lantus Solostar - Insulin Glargine Recombinant 100 UNIT/ML / Inject 20 unit subcutaneous at bedtime for DM
Ozempic (0.25 or 0.5 MG/DOSE) Subcutaneous Solution Pen-injector 2 MG/3ML / Inject 0.25 mg subcutaneous in the morning every Fri for DM2
BETADINE Solution 10 % / Apply to Left heel topically every day and evening shift for CELLULITIS AFTER CLEANSING WITH SALINE COVER WITH DRY DRESSING

14. DME and Supplies:

wound care supplies, wheelchair, walker, hospital bed, grab bars, diabetic supplies, commode, bath bench

15. Safety Measures:

walker precautions, wheelchair precautions, transfer with assist, standard precautions, sharps precautions, smoke detectors , medication safety, fall precautions, diabetic precautions, anticoagulant precautions, bleeding precautions, bedrails up while in bed, bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

diabetic

17. Allergies:

statins

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Wheelchair, 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: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:

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.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment

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:

Patient is an 88-year-old male recently discharged home from a rehabilitation facility following an approximately three-month hospitalization and rehabilitation stay related to sepsis. The patient resides at home with his wife and is primarily bedbound, although he is able to ambulate short distances to the bathroom using a walker. The patient's wife serves as his primary caregiver and is supportive in assisting with daily care needs; however, she reports significant personal health challenges, including end-stage cirrhosis of the liver, and stated she has been informed that her prognosis is limited. During the admission visit, the patient's wife requested assistance with completion of all admission paperwork and consent forms. The RN reviewed the documents and repeatedly offered the wife the opportunity to independently read the forms and ask questions regarding the content prior to signing. The wife declined multiple times, stating she did not wish to review the documents and expressed frustration regarding the amount of paperwork required. Following completion of the electronic admission process, the RN overheard the patient's wife expressing concerns to the patient's aide regarding the length of the visit and paperwork process. The RN reapproached the wife and again offered to review all admission documents and answer any questions; however, she declined further review and stated she did not have any concerns regarding the paperwork. Despite caregiver stress and emotional distress related to her own medical condition, no additional questions or requests for clarification were voiced. The patient has additional support from a nearby stepson who assists with caregiving needs as needed. He currently receives daily home health aide services through Always Best Care for approximately four hours per day. Assessment revealed a left heel pressure injury that is reportedly being managed by a nurse practitioner who performs home visits; however, the patient and spouse were unable to provide the practitioner's name. Wound care is reportedly scheduled to be performed daily by Personic staff, although the patient and spouse were uncertain regarding the start date of services. Skilled wound care was completed by

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/01/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Scott Maurer
2465 Route 97
Glenwood, MD 21738
PHONE: 4104899550 FAX: 14104895527 NPI: 1861554974

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 : 05/18/2026

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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the RN during today's visit in accordance with physician orders using available supplies. The patient has a significant cardiac history, including prior myocardial infarction requiring pacemaker placement. Vital signs were obtained and remained within acceptable parameters throughout the visit. The patient demonstrated no acute distress, remained clinically stable, and tolerated all assessment and treatment interventions without complication. Education was provided regarding ongoing wound care, safety, and available support services. At the conclusion of the visit, the patient remained stable with no additional questions or concerns voiced by either the patient or spouse. Patient was also evaluated for skilled home health physical therapy services following hospitalization for acute-on-chronic congestive heart failure exacerbation with preserved ejection fraction, significant fluid overload requiring aggressive diuresis, urinary retention necessitating Foley catheter placement, and generalized debility. Past medical history is significant for coronary artery disease status post percutaneous coronary intervention, congestive heart failure, chronic kidney disease stage III, paroxysmal atrial fibrillation, cardiac pacemaker, type 2 diabetes mellitus with diabetic chronic kidney disease, hypertension, hypothyroidism, history of prostate cancer, recurrent urinary tract complications, history of falls, and chronic mobility limitations. Physical therapy evaluation revealed generalized weakness, impaired balance, decreased endurance, impaired transfer ability, abnormal gait mechanics, and reduced overall functional mobility following recent hospitalization and medical decline. Functional deficits are further impacted by CHF-related activity intolerance, chronic kidney disease, advanced age, Foley catheter management requirements, and multiple chronic comorbidities, resulting in increased fall risk and dependence on assistance for safe mobility and activities of daily living. Skilled physical therapy services are medically necessary to address lower extremity weakness, balance impairments, gait dysfunction, transfer deficits, fall prevention strategies, reduced endurance, and progression of functional mobility to maximize independence, improve safety, and reduce the risk of rehospitalization. Prognosis is considered fair for improvement in functional mobility, safety awareness, and overall function with continued participation in skilled physical therapy services and adherence to the established plan of care.
 Date of Order 06/01/2026 Orders Physician Face-to-Face Date: 05/18/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat, hha-adl's, msw due to 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
 1 - SOC - SN Notes: PT Eval Notes:
 Physician Maurer, Scott

SN Careplans

SN WK1: 1 (06/01/26-06/06/26) ,WK2: 1 (06/07/26-06/13/26) ,WK3: 1 (06/14/26-06/20/26) ,WK4: 1 (06/21/26-06/27/26) ,WK5: 1 (06/28/26-07/04/26) ,WK6: 1 (07/05/26-07/11/26) ,WK7: 1 (07/12/26-07/18/26) ,WK8: 1 (07/19/26-07/25/26) ,WK9: 1 (07/26/26-07/30/26)

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 > 10

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

HOSPITALIZATION RISKS: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 7. Currently taking 5 or more medications, 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:ADVANCED DIRECTIVE: MOLST: 1a) ATTEMPT CPR

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, swelling in the arms/legs, M1400 - Dyspnea, M1033 - Unintentional Weight Loss, swelling in legs/around eyes, dependent edema, abn cholesterol > 200 mg/dL, abnormal blood pressure, abnormal electrolyte panel, abnormal BS < 70/140 > mg/dL, constipation, M1610 - Urinary Catheter, decreased urine output, swelling of affected area, difficulty sleeping, weak hand grips, obesity, red/tender pressure points, open sores/lesions, #1 - - Posterior Left Heel - , discolored patches of skin, bruising/discoloration

PROCEDURES: physician-ordered wound care: #1 - - Posterior Left Heel -: Ultra Mist therapy 2 times

SN Goals

PATIENT-STATED GOAL: Not to fall

GOALS
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
* 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
* strategies to increase caloric intake
* 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

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:	Date
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weekly by Personic Cleanse with Vashe allow 5 minute soak, Apply calcium alginate, apply ABD pad cover with bordered dressing secure with rolled gauze and tape daily, Caregiver to perform in the absence of the Nurse Additional Orders: apply Santyl to wound bed may use Medihoney until Santyl arrives Compression therapy to the left leg apply proper-size compressive single-layer TubiGrip bandage size E or F, change with dressing changes or as needed for soiling; elevate legs when possible, cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange transportation services

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 achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * strategies to increase caloric intake, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (06/01/26-06/06/26) ,WK2: 1 (06/07/26-06/13/26) ,WK3: 1 (06/14/26-06/20/26) ,WK4: 1 (06/21/26-06/27/26) ,WK5: 1 (06/28/26-07/04/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170M1 - 1 - Step (curb), 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, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170G1 - Car Transfer, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, poor muscle tone, limited range of motion, limited strength, limited endurance, muscle weakness, Pain Interference with ADLs, Pain Interference with ADLs, balance deficit

PROCEDURES: B LE mm strengthening: 1, physician-ordered wound care: Ultra Mist therapy 2 times weekly by Personic Cleanse with Vashe allow 5 minute soak, Apply calcium alginate, apply ABD pad cover with bordered dressing secure with rolled gauze and tape daily, Caregiver to perform in the absence of the Nurse Additional Orders: apply Santyl to wound bed may use Medihoney until Santyl arrives Compression therapy to the left leg apply proper-size compressive single-layer TubiGrip bandage size E or F, change with dressing changes or as needed for soiling; elevate legs when possible, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: exercises & training are successfully recalled/demonstrated , * 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 preventing pressure ulcer recurrence record wound measurements, 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 - 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, mobility is optimized, 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 - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 05. Setup or clean-up assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance

PT Goals

PATIENT-STATED GOAL: To be able to walk safer at home

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

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 - 04. Supervision or touching assistance

exercises & training are successfully recalled/demonstrated

patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* preventing pressure ulcer recurrence
* record wound measurements
* recalls related medication(s) purpose, schedule

Chair to Bed to Chair - 04. Supervision or touching assistance

Toilet Transfer - 05. Setup or clean-up assistance

mobility is optimized

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 - 04. Supervision or touching assistance

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

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

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

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

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