

Home Health Certification and Plan of Care				Order ID: 1150/19458	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
78144147		06/05/2026		From: 06/05/2026 To: 08/03/2026	
				4. Medical Record No.	
				26420	
				5. Provider No.	
				217058	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Darrell Harris			HomeCentris Healthcare LLC		
59 EASTFORD COURT,			10 Crossroads Drive, Suite 102		
PARKVILLE, MD 21234-			Owings Mills, MD 21117-8284		
443-985-8680			410-321-8448		
			1487113239		
8. DOB			9. Sex		
02/17/1947			Male		
11. ICD			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
148.0			CENTRUM ADULT PO Take 1 tablet by mouth once a day		
Principal Diagnosis			Dabigatran Etexilate - Dabigatran Etexilate 150 mg / 1 Capsule by mouth		
Paroxysmal atrial fibrillation			twice a day Commonly known as: PRADAXA		
13. ICD			Digoxin - Digoxin 125 mcg / 1 Tablet by mouth once a day Commonly		
148.92			known as: LANOXIN		
Other Pertinent Diagnoses			Furosemide - Furosemide 40 mg / 1 Tablet by mouth once a day Commonly		
148.92			known as: LASIX		
111.0			Levothyroxine - Levothyroxine Sodium 175 MCG tablet by mouth once a day		
Hypertensive heart disease with heart failure			before breakfast. Commonly known as: SYNTHROID		
150.23			Metoprolol Tartrate - Metoprolol Tartrate 25 mg / 1 Tablet by mouth twice a		
Acute on chronic systolic (congestive) heart failure			day		
125.10			Potassium Chloride - Potassium Chloride 10 meq / 1 Tablet by mouth once a		
Athscr heart disease of native coronary artery w/o ang			day Commonly known as: KLOR-CON		
pctrs			Metamucil 3 tab by mouth twice a day		
125.2					
Old myocardial infarction					
169.354					
Hemiplga following cerebral infrc affecting left nondom					
side					
E03.9					
Hypothyroidism unspecified					
K21.9					
Gastro-esophageal reflux disease without esophagitis					
E66.9					
Obesity unspecified					
F32.A					
Depression unspecified					
J84.9					
Interstitial pulmonary disease unspecified					
Z86.74					
Personal history of sudden cardiac arrest					
Z87.891					
Personal history of nicotine dependence					
Z79.01					
Long term (current) use of anticoagulants					
Z79.890					
Hormone replacement therapy					
14. DME and Supplies:			15. Safety Measures:		
walker, commode			standard precautions, fall precautions, cardiac precautions, ambulates with		
			assistance		
16. Nutrition:			17. Allergies:		
2gm sodium			amlodipine beta adrenergic blockers famotidine gabapentin losartan lyrica statin		
18.A. Functional Limitations			18.B. Activities Permitted		
Endurance, Ambulation			Exercises Prescribed, Transfer bed/Chair, 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: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes					
20. Prognosis: good					
22. A Rehabilitation Potential:			22.B.Discharge Plans		
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.			patient will be responsible for managing treatment		
Homebound status: Due to diagnosis of Paroxysmal atrial fibrillation, 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 a 79-year-old male referred to home health services following a recent hospitalization for atrial fibrillation and atrial flutter, during which he was medically treated and stabilized. Past medical history is significant for right cerebrovascular accident (CVA), hypertension, coronary artery disease, myocardial infarction, atrial fibrillation, atrial flutter, and depression. The patient resides in a two-story townhouse with three steps at the entrance equipped with a railing; the home environment is noted to be cluttered and unclean, and the patient was educated on home safety recommendations including removal of area rugs and clearing of pathways to reduce fall risk. Prior level of function included independence with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), no use of assistive device within the home, and independent functional mobility, although the patient does not drive and reports use of a rolling walker for community ambulation. Upon evaluation, the patient demonstrated impairments in gait, balance, strength, and stair negotiation. Objective testing revealed a Tinetti score of 15/28 and a Timed Up and Go (TUG) of 24 seconds, indicating an increased fall risk. The patient was also noted to be verbose and intermittently difficult to redirect during assessment. Occupational therapy evaluation indicates decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, and decreased activity tolerance, resulting in impaired independence with self-care tasks, functional transfers, and functional ambulation compared to prior level of function. Overall, the patient presents with functional decline secondary to recent cardiopulmonary hospitalization and pre-existing comorbidities. Skilled physical and occupational therapy services are medically necessary to address identified deficits in strength, balance, endurance, and functional mobility in order to reduce fall risk, improve safety within the home environment, and facilitate a return to prior level of function and independence. The patient demonstrates good potential to benefit from skilled intervention and to achieve improved functional independence with a structured rehabilitation program. Date of Order 06/05/2026 Orders Physician Face-to-Face Date: 05/28/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat, OT-eval & treat due to Paroxysmal atrial fibrillation 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 - PT Notes: soc OT Eval Notes: Physician Varghese, Sherin					
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 06/05/2026					
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.		
Sherin Varghese			F2F date : 05/28/2026		
2931 Greenspring Drive					
Timonium, MD 21093					
PHONE: FAX: NPI: 1952471153					
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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PT Careplans		PT Goals		
PT WK1: 1 (06/05/26-06/06/26) ,WK2: 2 (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) 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 > 9 CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to 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, 7. Currently taking 5 or more medications, 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:No Advance Directive PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, 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, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, M1720 - Anxiety, D0160 - Depression, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, cluttered/soiled living area (CM), unsafe floor coverings (CM), D0700 - Social Isolation, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, limited strength, limited endurance, muscle weakness, extremity burn/tingle/numb, Pain Interference with ADLs, Pain Interference		PATIENT-STATED GOAL: Pt get stronger, improve my walking and be steady GOALS Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance 1 - Step (curb) - 05. Setup or clean-up assistance Shower/Bathe Self - 05. Setup or clean-up assistance Toilet Transfer - 06. Independent 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 * 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 * 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 patient/caregiver recalls * strategies to increase socialization * recalls related medication(s) purpose, schedule patient living environment has safe floor coverings patient's living environment is clean/uncluttered caregiver administers and/or packages medications appropriately caregiver performs medical/rehabilitation treatments with adequate competence 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		
Signature of Physician:		Date		
		PAGE 2 of 3		
Optional Name/Signature of Nurse/Therapist:		Date		
Electronically Signed by Messick, Charles RN		06/05/2026		

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with Therapy activities, balance deficit, weak hand grips PROCEDURES: Medication management : Review medication with pt, cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, home exercise program: Seated and standing exercises 2-3x10 laq, hip flexion, hip abduction, hamstring curls, heelraises., equipment training, work simplification/energy conservation, dynamic standing balance exercises: Dynamic balance exercises to improve hip ankle step strategies a d reaction time, 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, * 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, * strategies to increase socialization, related medication(s) purpose, schedule, patient living environment has safe floor coverings, patient's living environment is clean/uncluttered, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet 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, Car Transfer - 05. Setup or clean-up assistance, 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	Car Transfer - 05. Setup or clean-up assistance 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 Sit to Stand - 05. Setup or clean-up assistance Chair to Bed to Chair - 05. Setup or clean-up assistance 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
OT Careplans OT WK2: 1 (06/07/26-06/13/26) ,WK4: 1 (06/21/26-06/27/26) ,WK6: 1 (07/05/26-07/11/26) ,WK8: 1 (07/19/26-07/25/26) ,WK10: 1 (08/02/26-08/03/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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, equipment training, work simplification/energy conservation 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, 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;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 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 - 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
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Optional Name/Signature of Nurse/Therapist:	Date
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