Home Health Certification and Plan of Care

Order ID: 1150/19555

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
32360901	06/08/2026	From: 06/08/2026 To: 08/06/2026	26545	217058

6. Patient's Name and Address
Donald Brown
7724 North Point Road,
Sparrows Point, MD 21219
410-477-4935

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 04/25/1945 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
N39.0	Urinary tract infection site not specified	06/08/26

13. ICD	Other Pertinent Diagnoses	Date
B96.1	Klebsiella pneumoniae as the cause of diseases classd elswhr	06/08/26
B96.5	Pseudomonas (mallei) causing diseases classd elswhr	06/08/26
I70.0	Atherosclerosis of aorta	06/08/26
I71.9	Aortic aneurysm of unspecified site without rupture	06/08/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	06/08/26
I10.	Essential (primary) hypertension	06/08/26
E11.9	Type 2 diabetes mellitus without complications	06/08/26
E78.5	Hyperlipidemia unspecified	06/08/26
I35.0	Nonrheumatic aortic (valve) stenosis	06/08/26
E27.8	Other specified disorders of adrenal gland	06/08/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	06/08/26

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

CARVEDILOL 3.125 mg / 1 Tablet by mouth daily
LISINOPRIL 30 mg / 1 Tablet by mouth daily
MECLIZINE 12.5 mg / 1 Tablet by mouth 3 (three) times daily as needed
METFORMIN 500 mg / 1 Tablet by mouth daily
OMEPRAZOLE Delayed Release 20 mg / 1 Capsule by mouth daily
ROSUVASTATIN CALCIUM 20 mg/tablet / Take 0.5 tablet by mouth daily
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg/capsule / Take 2 capsules by mouth nightly
Kaopectate - Bismuth Subsalicylate 2 tab by mouth as necessary Diarrhea
Allergyrelief 1 by mouth as necessary For allergies
Fiber - Benefiber 1 by mouth as necessary Fiber for bowels
NITROGLYCERIN 0.4 mg / 1 Tablet under the tongue every 5 (five) minutes as needed for Chest pain

14. DME and Supplies:
diabetic supplies, cane, commode

15. Safety Measures:
smoke detectors , fall precautions, bleeding precautions, ambulates with assistance, activity supervision

16. Nutrition:
2gm sodium!diabetic

17. Allergies:
No Known Allergies

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

18.B. Activities Permitted
Exercises Prescribed, Cane, 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: good

22. A Rehabilitation Potential:
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.

22.B.Discharge Plans
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Urinary tract infection site not specified, 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 81-year-old male referred for home health services following a recent hospitalization for weakness, chills, and urinary symptoms. During hospitalization, he was diagnosed with a urinary tract infection complicated by Klebsiella bacteremia. The patient received appropriate medical treatment, was stabilized, and subsequently discharged home for continued recovery and rehabilitation services. His past medical history is significant for hypertension, diabetes mellitus, hyperlipidemia, and benign prostatic hypertrophy. The patient resides in a ranch-style single-family home with his wife and adult son. He serves as a primary support for his wife and was previously independent with all activities of daily living (ADLs), instrumental activities of daily living (IADLs), community mobility, and driving without the use of an assistive device. Prior to hospitalization, he was fully independent in the home and community. A skilled physical therapy evaluation was completed. Assessment revealed deficits in lower extremity strength, gait sequencing, balance, stair negotiation, and overall functional endurance. Objective measures demonstrated a Tinetti Balance and Gait Assessment score of 19/28, indicating an increased risk for falls, and a Timed Up and Go (TUG) score of 11.6 seconds. These impairments have resulted in a decline from the patient's prior level of function and may impact his ability to safely perform mobility-related tasks within the home and community. The patient demonstrates good rehabilitation potential and is expected to benefit from skilled physical therapy interventions focused on improving strength, balance, gait mechanics, stair management, endurance, fall prevention, and overall functional mobility to facilitate a safe return to his prior level of independence. A skilled occupational therapy evaluation was also completed. Assessment findings revealed that the patient remains independent with basic self-care activities, functional transfers, and household ambulation. He demonstrated the ability to safely perform activities of daily living without physical assistance and exhibited functional performance consistent with his current living environment. Given his independence with self-care and functional mobility tasks, no additional occupational therapy interventions are indicated at this time. Skilled occupational therapy evaluation only was completed, and the patient was discharged from OT services following evaluation.
 Date of Order 06/08/2026 Orders Physician Face-to-Face Date: 06/01/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat , OT-eval & treat due to Urinary tract infection site not specified 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 Peters, Maria

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/08/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Maria Peters
104 Plumtree Rd
Belair, MD 21015
PHONE: 4437302020 FAX: 14106057872 NPI: 1295768372

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 : 06/01/2026

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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PT Careplans

PT WK1: 2 (06/08/26-06/13/26) ,WK2: 1 (06/14/26-06/20/26) ,WK3: 1 (06/21/26-06/27/26) ,WK4: 1 (06/28/26-07/04/26) ,WK5: 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: 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 on File

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170E1 - Chair to Bed to Chair, 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, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, Home Safety, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, abdominal pain, M1610 - Urinary Incontinence, M1600 - UTI, frequent urination, limited strength, limited endurance, muscle weakness, balance deficit, bruising/discoloration

PROCEDURES: Medication management : Review medication with pt, cough/deep breathing exercises, bladder training, home exercise program: Laq, standing: hip flexion, hamstring curls, hip abduction, heelraises as tolerated, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

PT Goals

PATIENT-STATED GOAL: To improve strength and endurance, amb Independently

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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 living environment has safe floor coverings

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

Signature of Physician:

Date

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

Date
06/08/2026

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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 including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin 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, patient living environment has safe floor coverings, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK1: 1 (06/08/26-06/13/26)

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

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 - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Evaluation only

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 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	06/08/2026