Home Health Certification and Plan of Care

Order ID: 1150/19527

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2ND9G16UR14	06/08/2026	From: 06/08/2026 To: 08/06/2026	26600	217058

6. Patient's Name and Address

Edward Blakslee
6600 Allen Ln,
COLUMBIA, MD 21045-
410-948-2828

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 12/05/1930 | **9.Sex** Male

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

Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg / 1 Capsule by mouth at bedtime for BPH
SIMVASTATIN 20 mg 20 mg / 1 Tablet by mouth at bedtime for HLD
ELIQUIS 2.5 mg / 1 Tablet by mouth every morning and at bedtime for AFib

11. ICD	Principal Diagnosis	Date
S72.002D	Fx unsp part of nk of l femr subs for clos fx w routn heal	06/08/26

13. ICD	Other Pertinent Diagnoses	Date
J44.9	Chronic obstructive pulmonary disease unspecified	06/08/26
I48.0	Paroxysmal atrial fibrillation	06/08/26
N18.31	Chronic kidney disease stage 3a	06/08/26
D63.1	Anemia in chronic kidney disease	06/08/26
E78.5	Hyperlipidemia unspecified	06/08/26
B44.0	Invasive pulmonary aspergillosis	06/08/26
I35.0	Nonrheumatic aortic (valve) stenosis	06/08/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	06/08/26
I95.9	Hypotension unspecified	06/08/26
K21.00	Gastro-esophageal reflux dis with esophagitis without bleed	06/08/26
R63.4	Abnormal weight loss	06/08/26
Z79.01	Long term (current) use of anticoagulants	06/08/26
Z96.642	Presence of left artificial hip joint	06/08/26
Z87.891	Personal history of nicotine dependence	06/08/26
Z91.81	History of falling	06/08/26

14. DME and Supplies:

wheelchair, bath bench, walker, cane

15. Safety Measures:

standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, ambulates with assistance, transfer with assist, supervision at all times, anticoagulant precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Bowel/Bladder Incontinence, Endurance, Ambulation

18.B. Activities Permitted

Up As Tolerated, Wheelchair, Cane, Walker, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 0. Never, 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, HISTORY OF DEPRESSION: No

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: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing, 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 95-year-old male recently discharged from a rehabilitation facility following hospitalization for a left femoral neck fracture sustained after a fall at home when he tripped over a footrest and landed on his left side. He subsequently underwent a left hip hemiarthroplasty on 04/30/2026 and completed an inpatient rehabilitation stay prior to returning home. His past medical history is significant for COPD, paroxysmal atrial fibrillation, chronic kidney disease stage III, hyperlipidemia, normocytic anemia, aortic stenosis, GERD, invasive pulmonary aspergillosis, benign prostatic hyperplasia (BPH), hypotension, generalized muscle weakness, gait instability, and a history of recurrent falls. During his recent hospitalization, the patient experienced episodes of hypotension and hypoxia, which resolved without further intervention. A notable decline in weight was observed during his stay, decreasing from 194.8 pounds to 171.1 pounds, prompting initiation of Ensure supplementation to improve nutritional status. Upon admission to home health services, the patient was alert and oriented to person and place but demonstrated intermittent forgetfulness, requiring occasional reorientation. He communicates primarily in Spanish and Portuguese. The patient denied pain and shortness of breath during assessment. Respiratory examination revealed fine crackles in the left lower lobe; however, respirations were non-labored, and no signs of acute respiratory distress were observed. Appetite has improved since discharge from the rehabilitation facility, and the patient reported his last bowel movement occurred the previous day. Suspected urinary incontinence was noted, as a urine odor was present during the skilled nursing visit and the patient was observed wearing an adult brief. The patient ambulates with a rollator walker and requires one-person assistance for safe mobility due to weakness, impaired balance, and increased fall risk. The left hip surgical incision was closed, well-approximated, and healing appropriately without signs or symptoms of infection. The patient resides in a single-family home with three steps to enter and lives with his son and daughter-in-law, who provide extensive assistance with all activities of daily living and instrumental activities of daily living. Additional functional concerns include hearing impairment, vision loss in the left eye, occasional swallowing difficulties, mild tremors, and reported difficulty managing financial affairs over the past year. Occupational therapy evaluation revealed the patient is modified independent with oral hygiene and requires standby assistance for upper body dressing and selected self-care tasks. He requires moderate assistance for bathing, lower body dressing, toileting hygiene, and functional ambulation. The patient is currently not participating in regular household or leisure activities and remains at risk for deconditioning, further functional decline, and falls. Physical therapy evaluation identified significant functional deficits related to recent hospitalization, surgery, and rehabilitation. The patient presents with bilateral lower extremity weakness, impaired balance, decreased endurance, altered gait mechanics, generalized weakness, and gait instability. These impairments contribute to difficulty with bed mobility, transfers, household ambulation, and safe

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

Joseph Gibbons
8186 Lark Brown Rd
Elkridge, MD 21075
PHONE: 410-730-3399 FAX: 14437304736 NPI: 1023124922

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 : 06/02/2026

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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navigation of the home environment, resulting in increased dependence on caregivers and assistive devices. Skilled physical therapy is medically necessary to provide lower extremity strengthening, transfer training, gait training, balance retraining, endurance conditioning, fall prevention interventions, and safety awareness education to maximize functional independence, reduce fall risk, and prevent rehospitalization. Skilled occupational therapy services are also warranted to address upper extremity strengthening, ADL retraining, energy conservation techniques, functional mobility, home safety, caregiver education, and strategies to improve overall quality of life. During the skilled nursing visit, all medications were reviewed with the patient and caregiver, including medication names, dosages, frequencies, purposes, and potential side effects. Education was provided regarding signs and symptoms of bleeding, medication safety, and proper monitoring and care of the healed surgical incision. The patient's daughter verbalized understanding of all instructions provided. The plan of care includes skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> twice weekly for one week followed by weekly <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> for three additional weeks to monitor cardiopulmonary status, nutritional status, continence issues, medication compliance, postoperative recovery, and overall safety. Ongoing skilled physical and occupational therapy evaluations and treatments have been ordered to improve strength, mobility, endurance, safety, and functional independence while supporting the patient's ability to remain safely in the home setting.
 Date of Order 06/08/2026 Orders Physician Face-to-Face Date: 06/02/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing 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 OT Eval Notes: PT Eval Notes:
 Physician Gibbons, Joseph

SN Careplans

SN 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)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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:Moist: 1d) No Cpr, Option B, Palliative And Supportive Care

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M1745 - Behavioral Issues, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, M1610 - Urinary Incontinence, limited range of motion, limited strength, limited endurance, balance deficit, bruising/discoloration

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 keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * management of

SN Goals

PATIENT-STATED GOAL: FAMILY WANTS HIM TO GET STRONGER AND WALK BETTER

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
* 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

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
* 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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/08/2026

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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, * 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, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (06/08/26-06/13/26) ,WK3: 1 (06/21/26-06/27/26) ,WK4: 1 (06/28/26-07/04/26) ,WK5: 1 (07/05/26-07/11/26) ,WK6: 1 (07/12/26-07/18/26) ,WK7: 1 (07/19/26-07/25/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet, GG0170E1 - Chair to Bed to Chair

PROCEDURES: B LE mm strengthening: 1, 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. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car 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, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent

PT Goals

PATIENT-STATED GOAL: to have a successful post surgical outcome

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Car 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

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

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

OT Careplans

OT WK1: 1 (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) ,WK6: 1 (07/12/26-07/18/26) ,WK7: 1 (07/19/26-07/25/26) ,WK8: 1 (07/26/26-08/01/26) ,WK9: 1 (08/02/26-08/06/26)

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: Therapeutic exercise : exes during the visit, Medication review : med list update, cough/deep breathing exercises, incentive spirometer, home exercise program: exes for home, 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: to be able to do more ADLs

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 - 03. Partial/moderate assistance

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