Home Health Certification and Plan of Care

Order ID: 1150/19519

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
8U81E42UG11	06/09/2026	From: 06/09/2026 To: 08/07/2026	26133	217058

6. Patient's Name and Address

Ronald Reely
555 Atwood Rd,
Bel Air, MD 21014
410-852-1671

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 02/07/1945 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
S82.102D	Unsp fx upper end of l tibia subs for clos fx w routn heal	06/09/26

13. ICD	Other Pertinent Diagnoses	Date
I48.91	Unspecified atrial fibrillation	06/09/26
I11.0	Hypertensive heart disease with heart failure	06/09/26
I50.9	Heart failure unspecified	06/09/26
I27.21	Secondary pulmonary arterial hypertension	06/09/26
J43.9	Emphysema unspecified	06/09/26
J96.11	Chronic respiratory failure with hypoxia	06/09/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	06/09/26
E78.00	Pure hypercholesterolemia unspecified	06/09/26
F32.A	Depression unspecified	06/09/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	06/09/26
Z86.718	Personal history of other venous thrombosis and embolism	06/09/26
Z98.61	Coronary angioplasty status	06/09/26
Z79.01	Long term (current) use of anticoagulants	06/09/26
Z99.81	Dependence on supplemental oxygen	06/09/26
Z91.81	History of falling	06/09/26

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

TORSEMIDE 20 mg 20 mg/tablet / Give 2 tablet by mouth one time a day every Mon, Wed, Fri for CONGESTIVE HEART FAILURE Take 2 tabs to equal 40mg
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg / 1 Capsule by mouth at bedtime for BPH
SPIRONOLACTONE 25 mg 25 mg / 1 Tablet by mouth in the morning for CONGESTIVE HEART FAILURE
SIMVASTATIN 20 mg 20 mg / 1 Tablet by mouth at bedtime for HYPERLIPIDEMIA
Senokot S - Senna 8.6-50 mg/tablet / Give 2 tablet by mouth at bedtime for constipation
MIRALAX 0 Powder / Give 17 gram by mouth in the morning for BOWEL REGIMEN, SHOULD BE MIXED WITH AT LEAST 8 OUNCES OF FLUID
FLUOXETINE 20 mg / 1 Capsule by mouth in the morning for DEPRESSION
ELIQUIS 2.5 mg / 1 Tablet by mouth every morning and at bedtime for ATRAL FIBRILLATION
ACETAMINOPHEN 500 mg/tablet / Give 2 tablet by mouth every 6 hours as needed for MILD TO SEVERE PAIN NOT TO EXCEED 3GM ACETAMINOPHEN PER DAY; Take 2 tabs to equal 1000mg
SYSTANE Solution 0.4-0.3 % / Instill 1 drop in both eyes two times a day for DRY EYES
INCRUSE ELLIPTA 0 Aerosol Powder Breath Activated 62.5 MCG/INH / 1 puff inhale orally in the morning for COPD
BUDESONIDE Suspension 0.5 MG/2ML / 2 ml inhale orally every morning and at bedtime for COPD. Rinse mouth after use VIA NEBULIZER HOB ELEVATED at 45%.TO AVOID SHORTNESS OF BREATH FOR COPD. *Must RINSE MOUTH AFTER USE*
ALBUTEROL HFA Aerosol Solution 108 (90 Base) MCG/ACT / 2 puff inhale orally every 24 hours as needed for SOB/ WHEEZING HOB ELEVATED AT 45% TO AVOID SHORTNESS OF BREATH FOR COPD.
Oxygen - Oxygen 3 L nasal cannula continuous Shortness of Breath
Albuterol Sulfate And Ipratropium Bromide - Albuterol Sulfate: Ipratropium Bromide Solution 0.5-2.5 (3) MG/3ML / 3 ml inhale orally every 6 hours for COPD VIA NEBULIZER. HOB ELEVATED AT 45% TO AVOID SHORTNESS OF BREATH FOR COPD.
Nitrostat - Nitroglycerin 0.4 mg / 1 Tablet sublingually every 5 minutes as needed for CHEST PAIN MAY REPEAT X 3 DOSES: NOTIFY MD IF NOT RESOLVED AND SEND TO ER *BLOOD PRESSURE AND PULSE TO BE TAKEN BEFORE EACH DOSE*

14. DME and Supplies:

walker, oxygen supplies, nebulizer, commode, bath bench

15. Safety Measures:

wheelchair precautions, walker precautions, standard precautions, O2 precautions, medication safety, knee precautions, fall precautions, bleeding precautions, bathroom safety, anticoagulant precautions, ambulates with device

16. Nutrition:

regular,

17. Allergies:

percocet

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Wheelchair, Walker

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: 8. Patient unable to respond, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

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

SN and OT: patient will be responsible for managing treatment PT: family/careg

Homebound status:

Due to diagnosis of Unspecified fracture of upper end of left tibia, 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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/09/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Vincenzo Grippo
2801 For Ave
Baltimore, MD 21224
PHONE: 4103420333 FAX: 14107327427 NPI: 1982646378

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 : 05/14/2026

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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patient needs assistance from another person and an assistive mobility device

Clinical Condition Requiring Homecare:

Skilled nursing, physical therapy, and occupational therapy evaluations were completed for an 81-year-old male with a significant medical history of COPD, congestive heart failure (CHF), severe pulmonary hypertension, atrial fibrillation, hypertensive heart disease, benign prostatic hyperplasia (BPH), chronic renal failure, hyperlipidemia, and depression. The patient was recently hospitalized and underwent a subacute rehabilitation stay following two falls that resulted in a left tibial fracture, managed conservatively with a knee immobilizer and extension brace without surgical intervention. Prior to hospitalization, he lived independently in a multi-level home, ambulated with a single-point cane, and independently managed transfers, mobility, and activities of daily living. Following discharge, he relocated to a senior living apartment with elevator access and receives assistance from his daughter, who serves as his primary caregiver. The patient is alert and oriented 4, oxygen-dependent at 3 L/min via nasal cannula, and utilizes a nebulizer, inhalers, walker, and wheelchair for mobility. Assessment revealed significant left lower extremity weakness, decreased range of motion with left hip and knee flexion contractures, impaired balance, decreased standing tolerance, reduced bilateral upper extremity strength, diminished activity tolerance, and impaired functional mobility, requiring assistance with transfers, bed mobility, and ambulation. He reports becoming easily short of breath during activities of daily living, often requiring extended time to complete self-care tasks. Skin assessment was unremarkable except for a small scabbed area on the right lower leg, and vital signs were within normal limits. Education was provided regarding medication management, oxygen safety, nebulizer use, fall prevention, and caregiver-assisted mobility techniques. The patient remains homebound due to impaired mobility, oxygen dependence, high fall risk, and the need for assistance to safely leave the home. Continued skilled nursing, physical therapy, occupational therapy, and home health aide services are medically necessary to monitor his cardiopulmonary status, improve strength, balance, endurance, and functional mobility, reduce fall risk, and maximize independence and safety within his living environment.<o:p></o:p>   Date of Order<o:p></o:p> 06/09/2026
Order<o:p></o:p> Physician Face-to-Face Date: 05/14/2026<o:p></o:p> Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Unspecified fracture of upper end of left tibia, subsequent encounter for closed fracture with routine healing<o:p></o:p> 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:<o:p></o:p> PT Eval Notes:<o:p></o:p> OT Eval Notes:<o:p></o:p> Physician: Grippo, Vincenzo

SN Careplans

SN WK1: 1 (06/09/26-06/13/26) ,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: 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), 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 3. Multiple hospitalizations (2 or more) in the past 6 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

SN Goals

PATIENT-STATED GOAL: To be comfortable moving around on my own.

GOALS
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,

Signature of Physician:

Date

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

Date
06/09/2026

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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: D0160 - Depression, M2020 - Oral Med Management, M1033 - Exhaustion, M1033 - Unintentional Weight Loss, M1400 - Dyspnea, muscle weakness, balance deficit, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises, incentive spirometer

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, * 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 increase caloric intake, 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

treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase caloric intake
* 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

PT Careplans

PT WK1: 1 (06/09/26-06/13/26) ,WK2: 2 (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 (08/02/26-08/07/26)

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, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Medication management : Review medication with pt and caregiver, Flexibility: Improve bilateral knee extension 10 degrees and L hip extension 10 degrees to improve balance and gait, Wc negotiation : Focus improved mgmt of wc throughout apt and hallway, home exercise program: Supine quad sets SLR, knee ext and hip extension stretching, laq, hip flexion, abduction, heel toe raises, hamstring curls, arom and aarom exercises, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 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 10 ft on Uneven Surface - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Wheel 150 feet - 06. Independent, Flexibility, Train dtr

PT Goals

PATIENT-STATED GOAL: To be able to stand and pivot myself use the bathroom without assist and hopefully walk with the Walker by ,yself;To be able to stand and pivot myself use the bathroom without assist and hopefully walk with the Walker by myself

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 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

Picking Up Object - 05. Setup or clean-up assistance

Wheel 150 feet - 06. Independent

Train dtr

Flexibility

OT Careplans

OT Goals

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
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OT WK1: 1 (06/09/26-06/13/26) ,WK3: 1 (06/21/26-06/27/26) ,WK5: 1 (07/05/26-07/11/26) ,WK7: 1 (07/19/26-07/25/26) ,WK9: 1 (08/02/26-08/07/26)

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, cough/deep breathing exercises, incentive spirometer, home exercise program: Bilateral UE triceps strengthening required to assist with ambulation. W/c press-ups, Yellow resistance bands triceps extensions, triceps kick backs, equipment training, work simplification/energy conservation, strengthening exercises: Skilled OT, transfers training: Skilled OT, assist with bathing: Skilled OT, assist with toilet transferring: Skilled OT

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 - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: 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 - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 4 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/09/2026