Home Health Certification and Plan of Care

Order ID: 1150/19753

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
78287091	04/15/2026	From: 06/14/2026 To: 08/12/2026	22707	217058

6. Patient's Name and Address

Larry Haynes
6 Pavia Ct Apt 2C,
ROSEDALE, MD 21237-
667-469-9910

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 05/26/1954 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
D47.2	Monoclonal gammopathy	04/15/26

13. ICD	Other Pertinent Diagnoses	Date
I87.2	Venous insufficiency (chronic) (peripheral)	04/15/26
L97.821	Non-prs chr ulcer oth prt l low leg limited to brkdwn skin	04/15/26
L97.811	Non-prs chr ulcer oth prt r low leg limited to brkdwn skin	04/15/26
I73.9	Peripheral vascular disease unspecified	04/15/26
L97.512	Non-prs chronic ulcer oth prt right foot w fat layer exposed	04/15/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	04/15/26
I10.	Essential (primary) hypertension	04/15/26
I89.0	Lymphedema not elsewhere classified	04/15/26
J44.9	Chronic obstructive pulmonary disease unspecified	04/15/26
F17.210	Nicotine dependence cigarettes uncomplicated	04/15/26
D50.9	Iron deficiency anemia unspecified	04/15/26
M48.061	Spinal stenosis lumbar region without neurogenic claud	04/15/26
F41.9	Anxiety disorder unspecified	04/15/26
I70.0	Atherosclerosis of aorta	04/15/26
G56.03	Carpal tunnel syndrome bilateral upper limbs	04/15/26
N49.1	Inflam disorders of sperm cord tunica vaginalis and vas def	04/15/26
E63.9	Nutritional deficiency unspecified	04/15/26
M51.362	Oth intvrt disc degen lum rgn w/o lum bck or lw extrm pain	04/15/26
S72.002D	Fx unsp part of nk of l femr subs for clos fx w routn heal	04/15/26
R73.03	Prediabetes	04/15/26
E66.9	Obesity unspecified	04/15/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	04/15/26
Z79.82	Long term (current) use of aspirin	04/15/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	04/15/26
Z79.1	Long term (current) use of non-steroidal non-inflam (NSAID)	04/15/26
Z91.81	History of falling	04/15/26

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

Lasix - Furosemide 20 mg / 1 Tablet by mouth once a day
Celebrex - Celecoxib 100 mg 2 by mouth twice a day For pain
Acetaminophen - Acetaminophen 500mg; 2 tabs by mouth every 8 hours as needed for pain
Asa 81 Mg - Aspirin 81ng; 1 tab by mouth once a day cad
Lipitor - Atorvastatin Calcium eq 80 mg base / 1 Tablet by mouth once a day CAD
Wellbutrin Xl - Bupropion Hydrochloride 300 mg 300MG; 1 TAB by mouth once a day ANXIETY
Furosemide - Furosemide 20 mg 20MG; 1 TAB by mouth once a day EDEMA
Lexapro - Escitalopram Oxalate eq 10 mg base 10MG; 1 TAB by mouth once a day ANXIETY
Lisinipril - Hydrochlorothiazide: Lisinopril 40MG; 1 TAB by mouth once a day HTN
Singulair - Montelukast Sodium eq 10 mg base 10MG; 1 TAB by mouth once a day every evening ASTHMA/ALLERGY
Plavix - Clopidogrel Bisulfate eq 75 mg base 75MG; 1 TAB by mouth once a day BLOOD THINNER
Miralax - Polyethylene Glycol 3350 17gm/scoopful 17GM; 1 SCOOP by mouth once a day AS NEEDED FOR CONSTIPATION
Senna Plus - Senna 8.6-50MG; 1 TAB by mouth twice a day FOR CONSTIPATION
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg 0.4MG; 1 TAB by mouth once a day BPH
Astelin - Azelastine Hydrochloride 0.1 % nasal solution / 2 sprays nasal twice a day
Voltaren - Diclofenac Sodium 4 g topical twice a day
Aspercreme 4%; 1 application topical twice a day mid back for pain
Buprenorphine Hydrochloride - Buprenorphine Hydrochloride 20MCG/HR; 1 PATCH transdermal once a week FOR PAIN
Nicotine Patch - Nicotine Patch 14MG/24HR; 1 PATCH transdermal once a day SMOKING CESSATION

14. DME and Supplies:
wheelchair, walker, reacher, grab bars, commode, wound care supplies, hospital bed

15. Safety Measures:
walker precautions, fall precautions, bleeding precautions, ambulates with device, wheelchair precautions, standard precautions, anticoagulant precautions

16. Nutrition:
low sodium

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Up As Tolerated,

19. Mental & Pyschosocial Status: COGNITION: 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer, ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: , MOBILITY:

22.B.Discharge Plans
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Monoclonal gammopathy, 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 was recently hospitalized due to bilateral lower extremity weakness, difficulty walking, and recurrent falls. MRI findings revealed multilevel disc disease in both the cervical and lumbar spine. Past medical history is significant for COPD, monoclonal gammopathy, hypertension, active smoking, allergic rhinitis, history of stroke, anxiety, and anemia. The patient reports severe pain, left leg stiffness, limited range of motion, and is noted to have a flexion deformity of the left knee with nonunion of a left hip fracture, requiring non-weight-bearing status on the left lower extremity. The patient is currently wheelchair-bound and dependent on assistance for bed mobility, transfers, and activities of daily living, with support from a spouse. Physical assessment shows bilateral trace to +1 edema and dry, scaly skin with scattered old blisters; wound care includes calcium alginate dressings secured with ACE wraps. The patient is alert and oriented, denies shortness of breath, reports good appetite, and is on a bowel regimen including Miralax and senna. Skilled nursing has provided medication education, skin care instruction, and coordinated wound supplies. Due to decreased strength, balance, and activity tolerance, skilled PT and OT services have been ordered, although rehabilitation prognosis is considered poor given the patient's current condition and functional decline from prior independence.
 Date of

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/12/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Chetan Sharma
1447 York Rd
Lutherville-Timonium, MD 21093
PHONE: FAX: NPI: 1477734341

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 : 04/10/2026

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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Order 06/12/2026 Orders Physician Face-to-Face Date: 04/10/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management, PT-eval & treat, OT-eval & treat due to Monoclonal gammopathy Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 4 - Recertification Notes: The patient is being recertified due to unhealed bilateral lower extremities with scattered wounds. With a history of lymphedema, the patient is prone to blisters, which occasionally burst, leading to open wounds that drain copious amounts.
 Physician Sharma, Chetan

SN Careplans

SN WK1: 1 (06/14/26-06/20/26) ,WK2: 1 (06/21/26-06/27/26) ,WK3: 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: 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: abnormal blood pressure, dependent edema, muscle weakness, balance deficit, #2 - Open Wound - Anterior Left Foot - wound care done

PROCEDURES: physician-ordered wound care: #2 - Open Wound - Anterior Left Foot - wound care done, physician-ordered wound care: #1 - Other - Other - BILATERAL LOWER LEG SCATTERED OPEN AREAS/OLD BLISTERS -: SN/CG TO CLEANSE LEGS WITH SOAP AND WATER OR NSS, APPLY CA ALGINATE IF LEGS ARE DRAINING; COVER WITH DRY DRESSING, WRAP WITH ACE WRAPS EVRY 2-3 DAYS OR NEEDED FOR SOILED 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, * 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 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

SN Goals

PATIENT-STATED GOAL: I WANT THE WOUNDS TO HEAL.

GOALS
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

meal preparation is available to patient for all meals

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

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/12/2026