# Home Health Certification and Plan of Care

**Order ID: 1150/19697**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 21303491 | 06/11/2026 | From: 06/11/2026 To: 08/09/2026 | 25064 | 217058 |

**6. Patient's Name and Address**

Dana Wilson
1100 BOLTON STREET APT 901,
BALTIMORE, MD 21201-
410-499-9679

**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** 07/04/1948 | **9.Sex** Male

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| J44.1 | Chronic obstructive pulmonary disease w (acute) exacerbation | 06/11/26 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| B44.81 | Allergic bronchopulmonary aspergillosis | 06/11/26 |
| I10. | Essential (primary) hypertension | 06/11/26 |
| E11.9 | Type 2 diabetes mellitus without complications | 06/11/26 |
| I69.351 | Hemiplga following cerebral infrc aff right dominant side | 06/11/26 |
| K21.9 | Gastro-esophageal reflux disease without esophagitis | 06/11/26 |
| E78.5 | Hyperlipidemia unspecified | 06/11/26 |
| G47.00 | Insomnia unspecified | 06/11/26 |
| I25.2 | Old myocardial infarction | 06/11/26 |
| R91.1 | Solitary pulmonary nodule | 06/11/26 |
| M19.90 | Unspecified osteoarthritis unspecified site | 06/11/26 |
| Z85.46 | Personal history of malignant neoplasm of prostate | 06/11/26 |
| Z87.891 | Personal history of nicotine dependence | 06/11/26 |
| Z79.82 | Long term (current) use of aspirin | 06/11/26 |
| Z79.84 | Long term (current) use of oral hypoglycemic drugs | 06/11/26 |
| Z79.52 | Long term (current) use of systemic steroids | 06/11/26 |

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

AMLODIPINE 10 mg / 1 Tablet by mouth daily Commonly known as: NORVASC
CARVEDILOL 12.5 mg / 1 Tablet by mouth 2 times daily with meals Commonly known as: COREG
ASPIRIN Chewable 81 mg / 1 Tablet by mouth daily
ATORVASTATIN 10 mg / 1 Tablet by mouth nightly Commonly known as: LIPITOR
LOSARTAN POTASSIUM 100 mg / 1 Tablet by mouth daily Commonly known as: COZAAR
METFORMIN 500 mg / 1 Tablet by mouth 2 times daily with meals Commonly known as: GLUCOPHAGE
NORTRIPTYLINE HYDROCHLORIDE 10 mg / 1 Capsule by mouth nightly Commonly known as: PAMELOR
Gabapentin - Gabapentin 300 mg 300mg=1tablet by mouth three times a day
Omeprazole - Omeprazole 20 mg 20mg=1tablet by mouth once a day
fluticasone-salmeterol 500-50 MCG/ACT inhaler, take 1 puff inhalation 2 times daily Commonly known as: Wixela Inhub
Spiriva Respimat - Tiotropium Bromide 2.5 MCG/ACT Aers inhaler, take 2 puffs inhalation daily
FLUTICASONE 50 MCG/ACT nasal spray, 2 sprays by Each Nare Nasal daily Commonly known as: FLONASE
albuterol-ipratropium 0.5-2.5 (3) mg/3mL nebulizer solution, take 3 mLs nebulization every 4 hours as needed for Wheezing (sob). Commonly known as: DUO-NEB

**14. DME and Supplies:**

diabetic supplies, wheelchair, walker, bath bench

**15. Safety Measures:**

fall precautions, medication safety, wheelchair precautions, standard precautions, walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with device

**16. Nutrition:**

diabetic

**17. Allergies:**

no known allergies

**18.A. Functional Limitations**

Endurance, , Ambulation

**18.B. Activities Permitted**

Transfer bed/Chair, Wheelchair, Walker, Exercises Prescribed, 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: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

**20. Prognosis:** good

**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**

SN: family/caregiver will be responsible for managing treatment
PT: patient will be responsible for managing treatment

**Homebound status:** Due to diagnosis of Chronic obstructive pulmonary disease with (acute) exacerbation, 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 77-year-old male admitted to home health services following a recent hospitalization for an acute exacerbation of chronic obstructive pulmonary disease (COPD). His past medical history is significant for COPD, hypertension, type 2 diabetes mellitus, hyperlipidemia, coronary artery disease with a history of myocardial infarction, cerebrovascular accident (left CVA with residual right-sided hemiparesis), prostate cancer, gastroesophageal reflux disease (GERD), and a history of spinal surgeries x2. The patient resides alone in an elevator-accessible apartment and receives regular assistance and support from his children as needed. Skilled nursing admission assessment was completed. The patient was alert and oriented, cooperative throughout the visit, and able to communicate his needs appropriately. Vital signs were within normal limits, and no acute distress was observed. Skin assessment revealed intact skin with no evidence of pressure injuries, open areas, or other skin integrity concerns. The patient ambulates with a rolling walker and requires the assistive device for safe mobility. He remains at increased risk for falls due to impaired balance, generalized weakness, residual right-sided deficits from prior CVA, and decreased functional endurance following recent hospitalization. Physical therapy evaluation revealed functional limitations related to weakness, impaired balance, decreased endurance, and reduced mobility. The patient ambulated approximately 30 feet on indoor surfaces using a rolling walker with supervision. Bed mobility, transfers to and from bed, chair, and toilet were completed with supervision. Community mobility and car transfer abilities were not assessed during the evaluation. The patient is considered homebound due to the significant physical effort required to leave the home, reliance on assistive devices, decreased endurance, and elevated fall risk. Objective assessment demonstrated impaired balance with a Tinetti Balance Assessment score of 12/28, indicating a high risk for falls. During the visit, the patient tolerated 10 repetitions of therapeutic exercises performed in the supine position, including hip flexion, bridging, hook-lying trunk rotations, straight leg raises, hip abduction, knee extensions, and ankle pumps. Education was provided regarding fall prevention and home safety measures, including maintaining a clean and clutter-free living environment, ensuring adequate lighting throughout the home, removing potential tripping hazards, wearing appropriate non-slip footwear, and consistently utilizing the rolling walker during ambulation. Additional education was provided regarding medication adherence, disease process management for COPD and other chronic conditions, recognition of worsening symptoms, and the importance of promptly notifying the physician of any changes in respiratory status, increased shortness of breath, weakness, dizziness, falls, or other concerning symptoms. The patient verbalized understanding of all teaching provided. The patient would benefit from continued skilled nursing services for ongoing cardiopulmonary assessment, disease management, medication education, safety monitoring, and reinforcement of patient and caregiver teaching. Continued skilled physical therapy is medically necessary to address lower extremity weakness, balance deficits, gait impairment, transfer safety, endurance limitations, and fall prevention strategies. The goal of treatment is to improve strength, mobility, functional independence, and safety within the home and community, enabling the patient to return to his highest attainable level of function while reducing the risk of falls, hospitalization, and further functional decline. <br> Date of Order 06/11/2026 Orders Physician Face-to-Face Date: 06/08/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Chronic obstructive pulmonary disease with (acute) exacerbation Homebound Status per Certifying Physician: patient requires another person or

**23. Signature and Date of Verbal SOC Where Applicable:**

Electronically Signed by Messick, Charles RN on 06/11/2026

**25. Date HHA Received Signed POT**

**24. Physician's Name and Address**

Sherell Mason
815 E. Pratt Street
Baltimore, MD 21202
PHONE: 410-637-5700 FAX: 14106375661 NPI: 1750375481

**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 : 06/08/2026

**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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medical equipment such as crutches, a walker, or a wheelchair to leave home <br> 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes: <br> Physician Mason, Sherell

## SN Careplans

SN WK1: 1 (06/11/26-06/13/26) ,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)

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: 3. Multiple hospitalizations (2 or more) in the past 6 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

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: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, insects/rodents present (CM), cluttered/soiled living area (CM), A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, M1400 - Dyspnea, M1610 - Urinary Incontinence, limited strength, limited endurance, limited range of motion, B1000 - Vision Deficit, Pain Interference with ADLs, Pain Effect on Sleep, balance deficit, weak hand grips, daytime fatigue

PROCEDURES: teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange for maintenance of clean/uncluttered living area, coordinate/arrange resources for vision-impaired

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, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient's living environment is clean/uncluttered, insects/rodents not present in the patient's living environment, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

## SN Goals

PATIENT-STATED GOAL: Patient stated he would like to remain free of fall and regain strength

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

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

patient's living environment is clean/uncluttered

insects/rodents not present in the patient's living environment

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

| Signature of Physician: | Date |
|---|---|
| | PAGE 2 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 06/11/2026 |

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## PT Careplans

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PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170G1 - Car Transfer, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170F1 - Toilet Transfer

PROCEDURES: home exercise program: Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, equipment training, work simplification/energy conservation, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, 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 - 05. Setup or clean-up assistance, Upper Body Dressing - 06. Independent

## PT Goals

PATIENT-STATED GOAL: To be able to walk to get in my daughter's car

GOALS
Toilet Transfer - 06. Independent

Shower/Bathe Self - 05. Setup or clean-up assistance

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

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

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 - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Eating - 05. Setup or clean-up assistance

Signature of Physician:

Date



Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

06/11/2026