Home Health Certification and Plan of Care

Order ID: 1150/19832

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
41504256500	06/11/2026	From: 06/11/2026 To: 08/09/2026	16826	217058

6. Patient's Name and Address

David Thacker
69 N. Dundalk Avenue,
DUNDALK, MD 21222-
410-921-5532

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 09/26/1958 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I13.2	Hyp hrt & chr kdny dis w hrt fail and w stg 5 chr kdny/ESRD	06/11/26

13. ICD	Other Pertinent Diagnoses	Date
I50.22	Chronic systolic (congestive) heart failure	06/11/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/11/26
N18.6	End stage renal disease	06/11/26
Z99.2	Dependence on renal dialysis	06/11/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	06/11/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	06/11/26
F41.9	Anxiety disorder unspecified	06/11/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	06/11/26
E78.00	Pure hypercholesterolemia unspecified	06/11/26
Z94.0	Kidney transplant status	06/11/26
Z98.1	Arthrodesis status	06/11/26
Z91.81	History of falling	06/11/26

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

Aspirin 81Mg - Aspirin 81 mg , Take 1 tablet by mouth once a day Take 1 tablet (81 mg total) by mouth daily.
PROPHYLACTIC
Extra Strength Tylenol - Acetaminophen 500mg, 2 tablets by mouth every 6 hours As needed for pain.
Lipitor - Atorvastatin Calcium eq 40 mg base 40 MG , Take 1 tablet by mouth Take 1 tablet (40 mg total) by mouth every evening.
CHOLESTEROL
Neurontin - Gabapentin 100 mg 100 MG , Take 1 capsule by mouth three times a day Take 1 capsule (100 mg total) by mouth 3 times per week. Take after dialysis
You were taking this medication differently than prescribed.
Renvela - Sevelamer Carbonate 800 mg 800 mg , Take 1 tablet by mouth three times a day Take 1 tablet (800 mg total) by mouth 3 (three) times daily with meals.
Zyrtec - Cetirizine Hydrochloride 10mg by mouth once a day Take 1 5ab daily for alle4gies
Midodrine Hydrochloride - Midodrine Hydrochloride 2.5 mg Take 1 tablet by mouth three times a day At 6am, 10am, 2pm.
OZEMPIC 0.25mg subcutaneous once a week FOR DM

14. DME and Supplies:

rolling walker, cane

15. Safety Measures:

no bp left arm, fall precautions, medication safety

16. Nutrition:

regular

17. Allergies:

cefepime cipro latex

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

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

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease, 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 67-year-old African American male admitted to home health services following a recent hospitalization and short stay at an acute care facility secondary to a mechanical fall without loss of consciousness. During hospitalization, the patient was found to be hypotensive and required intravenous fluid resuscitation. No fractures or other traumatic injuries were identified. He was also diagnosed with hypertensive heart disease and congestive heart failure, treated, stabilized, and subsequently discharged home. His past medical history is significant for end-stage renal disease (ESRD) requiring hemodialysis three times weekly (Monday, Wednesday, and Friday), nonobstructive coronary artery disease, type 2 diabetes mellitus, hypertension, failed kidney transplant, cervical myelopathy, obstructive sleep apnea, osteomyelitis, chronic low back and neck pain, and other associated comorbidities. Upon admission to home health, the patient was observed ambulating throughout the home with the use of a cane. He was alert and oriented to person, place, time, and situation and able to communicate his needs appropriately. The patient reported persistent neck and low back pain that intermittently flares and negatively impacts his gait, balance, stair negotiation, and overall mobility. He is anuric secondary to ESRD and receives routine hemodialysis treatments via a functioning left upper extremity arteriovenous fistula. The patient reported his last bowel movement occurred the previous evening. Physical assessment revealed lungs clear to auscultation bilaterally, audible bowel sounds in all quadrants, palpable peripheral pulses, and trace bilateral lower extremity edema. Vital signs were obtained, a comprehensive assessment was completed, and medications were reviewed and reconciled upon admission. The patient resides alone in a two-story townhouse with six steps to enter the home and a single handrail. The home environment was noted to be significantly cluttered and soiled, with multiple tripping hazards present throughout the residence. Education was provided regarding fall prevention and home safety, including recommendations to clear pathways, remove excess clutter, and improve environmental safety to reduce fall risk. Prior to hospitalization, the patient was generally independent with transfers, ambulation within the home using a cane, and stair negotiation. For longer community distances, he utilized either a rollator walker or scooter due to chronic pain and reduced endurance. The patient continues to attend scheduled hemodialysis treatments three times weekly. Physical therapy evaluation revealed decreased lower extremity strength, impaired balance, reduced endurance, gait abnormalities, and difficulty with stair negotiation and functional mobility. Standardized testing demonstrated a Tinetti Balance and Gait Assessment score of 14/28, indicating a high risk for falls, and a Timed Up and Go (TUG) score of 54 seconds, reflecting significantly impaired mobility and increased fall risk. The patient reports that low back pain frequently limits his mobility and functional performance. Skilled physical therapy is medically necessary to address strength deficits, improve balance, gait mechanics, endurance, stair negotiation, and overall functional mobility, with the goal of reducing fall risk, improving safety, and maximizing independence within the home and community. An occupational therapy evaluation was also completed. The patient currently demonstrates decreased standing balance, limited standing tolerance, reduced bilateral upper extremity strength, impaired activity tolerance, and decreased safety during self-care and functional mobility tasks. These deficits have resulted in a decline in independence with activities of daily living, functional transfers, and household ambulation compared to his prior level of function. Skilled occupational therapy services are recommended to improve upper extremity strength, activity tolerance, balance, safety awareness, and performance of self-care tasks in order to facilitate a return to his highest attainable level of function and independence. The patient remains homebound due to impaired mobility, chronic pain, decreased endurance, dependence on an assistive device for ambulation, ongoing dialysis treatments, and the considerable effort required to safely leave the home. Skilled nursing, physical therapy, and occupational therapy services are warranted for ongoing assessment, disease process management, medication education, cardiopulmonary monitoring, dialysis access monitoring, pain management, fall prevention, home safety training, strengthening, balance training, and restoration of functional independence. Continued interdisciplinary home health services are medically necessary to reduce the risk of falls, prevent rehospitalization, and promote optimal health and safety in the home environment.
 Date of

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

Pankaj Kheterpal
223 Eastern Ave
Essex, MD 21221
PHONE: 410-687-8818 FAX: 14106823989 NPI: 1801813746

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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Order 06/11/2026 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 due to Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease 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 PT Eval Notes: OT Eval Notes:
 Physician Kheterpal, Pankaj

SN Careplans

SN WK1: 1 (06/11/26-06/13/26) ,WK2: 2 (06/14/26-06/20/26) ,WK3: 2 (06/21/26-06/27/26)

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: 4. Assistance needed, but no non-agency caregiver(s) available

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 7. Currently taking 5 or more medications, 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

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, Financial, inadequate food storage (CM), cluttered/soiled living area (CM), M2020 - Oral Med Management, D0700 - Social Isolation, inadequate meal prep facilities (CM), dependent edema, M1400 - Dyspnea, dizziness/syncope, delayed capillary refill, swelling in the arms/legs, limited endurance, Pain Interference with ADLs, Pain Effect on Sleep, balance deficit, #1 - Abrasion - Anterior Right Foot - Right upper leg, #2 - Abrasion - Anterior Right Foot - Right lower leg, #3 - Abrasion - Anterior Left Foot - Left upper leg, #4 - Abrasion - Anterior Left Foot - Left lower leg

PROCEDURES: cough/deep breathing exercises, physician-ordered wound care: #1 - Abrasion - Anterior Right Foot - Right upper leg #2 - Abrasion - Anterior Right Foot - Right lower leg #3 - Abrasion - Anterior Left Foot - Left upper leg : #4 - Abrasion - Anterior Left Foot - Left lower leg Cleane the BLE wounds with NSS, apply xeroform, cover with a dry gauze and secure with a kerlix. Change dressing daily., teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate meal prep facilities, coordinate/arrange for maintenance of clean/uncluttered living area, coordinate/arrange access to adequate food storage, coordinate/arrange patient access to necessary nutrition considering patient inability to pay, coordinate/arrange long-term socialization activities

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, * prevention exacerbation of anxiety condition

SN Goals

PATIENT-STATED GOAL: "I don;t want to fall again."

GOALS
patient/caregiver recalls
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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

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's living environment is clean/uncluttered

patient has access to necessary nutrition considering patient inability to pay

caregiver performs medical/rehabilitation treatments with adequate competence

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

patient has access to adequate food storage

patient is adequately supervised

caregiver administers and/or packages medications appropriately

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
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient has adequate meal prep facilities

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

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including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule, patient has adequate meal prep facilities, patient's living environment is clean/uncluttered, patient has access to adequate food storage, patient has access to necessary nutrition considering patient inability to pay, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 3 (06/11/26-06/13/26) ,WK2: 3 (06/14/26-06/20/26)

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, home exercise program: As needed supine: slr, hamstring stretch 20 second holds, seated laq, hip abduction, hamstring curls as tolerated, standing heelraises, hamstring curls, hip flexion, hip abduction, dynamic standing balance exercises: Focus righting reaction time, use hip ankle step strategies, gait training on uneven surfaces: Amb with LRAD vs no AD over all surfaces mod I lof, gait training/stair training: Negot flight of steps single handrail to mod I, 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 - 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

PT Goals

PATIENT-STATED GOAL: To improve my balance, strengthening amd walking ability

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK2: 1 (06/14/26-06/20/26) ,WK4: 1 (06/28/26-07/04/26) ,WK6: 1 (07/12/26-07/18/26) ,WK8: 1 (07/26/26-08/01/26)

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, home exercise program: Gravity decreased plane bilateral biceps curls, triceps extensions and kickbacks utilizing yellow resistance bands 3-4 sets 10-12 reps, equipment training, work simplification/energy conservation, transfers training: Skilled OT, assist with bathing: Skilled OT, assist with lower body dressing: 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 - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

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 - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

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