Home Health Certification and Plan of Care

Order ID: 1150/19853

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
4FN0G62TG44	06/14/2026	From: 06/14/2026 To: 08/12/2026	26927	217058

6. Patient's Name and Address

Carl Jones
931 Edgewood Road Apt. 102,
Annapolis, MD 21403-
443-306-4551

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 08/04/1945 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
G20.A1	Parkinson's dis w/o dyskinesia w/o mention of fluctuations	06/14/26

13. ICD	Other Pertinent Diagnoses	Date
D64.9	Anemia unspecified	06/14/26
I48.91	Unspecified atrial fibrillation	06/14/26
I10.	Essential (primary) hypertension	06/14/26
E03.9	Hypothyroidism unspecified	06/14/26
B18.1	Chronic viral hepatitis B without delta-agent	06/14/26
K63.1	Perforation of intestine (nontraumatic)	06/14/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	06/14/26
Z79.01	Long term (current) use of anticoagulants	06/14/26
Z91.81	History of falling	06/14/26

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

ATORVASTATIN 40mg; 1tab by mouth once a day cholesterol
OXYBUTYNIN 10mg; 1 tab by mouth once a day bladder
Asa 81 Mg - Aspirin 81mg; 1 tab by mouth once a day heart
LEVOTHYROXINE 50 mcg; 1 tab by mouth once a day thyroid
LOSARTAN POTASSIUM 100 mg 100mg; 1 tab by mouth once a day blood pressure
Eliquis - Apixaban 5mg; 1 tab by mouth twice a day blood thinner/ a-fib
Dicyclomine - Dicyclomine Hydrochloride 10mg; 1 cap by mouth four times a day IBS/PERFORATED BOWEL
Entecavir - Entecavir 0.5MG; 1 TAB by mouth once a day HEP B
METHOCARBAMOL 750 mg 750mg; 1 tab by mouth every 8 hours as needed for muscle spasms
Acetaminophen - Acetaminophen 325 mg 325mg; 2 tabs by mouth every 6 hours as needed for pain
Protonix - Pantoprazole Sodium eq 40 mg base 40 mg; 1 tab by mouth once a day stomach
SINEMET 25 mg;100 mg 25mg-100mg; 1 tab by mouth three times a day parkinson's disease
METOPROLOL 25 MG Oral two times a day Hold if SBP is less than 110 or HR is less than 60
blood pressure

14. DME and Supplies:

grab bars, walker

15. Safety Measures:

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

16. Nutrition:

regular

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Walker, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, 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
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Parkinson's disease without dyskinesia, without mention of fluctuations, 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 an 80-year-old male admitted to home health services following hospitalization and rehabilitation after a motor vehicle accident on 03/27/26, during which he sustained a ruptured small intestine requiring hospitalization for approximately three weeks followed by subacute rehabilitation through 06/12/26. His past medical history is significant for cerebrovascular accident, Parkinson's disease, hypertension, chronic left frozen shoulder, anemia, bowel perforation status post exploratory laparotomy on 03/24/26, atrial fibrillation, hypothyroidism, chronic hepatitis B, and right pleural effusion. Prior to the accident, the patient lived independently in his own home, ambulated primarily with a cane, and required minimal assistance with some activities of daily living. He currently resides alone in a senior living facility with caregiver support available approximately 10 hours per week. Skilled nursing assessment revealed the patient to be alert and oriented x3, denying pain at the time of the visit, shortness of breath, or other acute concerns. According to his daughter, he was recently evaluated in the emergency department for left shoulder pain and instructed to take prescribed muscle spasm medication, with Tramadol pending pharmacy pickup. Lung sounds were clear, appetite was reported as good, bowel movement occurred on the day of assessment, and the patient utilizes a walker/rollator for safe ambulation. Medication reconciliation was completed, and education was provided regarding medication administration, dosage, frequency, potential side effects, signs and symptoms of bleeding, and effective pain management strategies. The patient and daughter verbalized understanding of all teaching provided. Physical therapy evaluation was completed with consents obtained. Since discharge from rehabilitation, the patient has been using a rollator for mobility and demonstrates significant functional decline compared to his prior level of function. He reports approximately two falls within the last two months and as many as five falls within the past year. Assessment identified left shoulder pain, decreased functional mobility, unsteady gait, transfer deficits, impaired balance, decreased safety awareness, and a significant history of falls, placing him at high risk for future falls and injury. Homebound status is supported by the patient's need for a rollator and human assistance to safely leave the home. Skilled physical therapy is medically necessary to address gait instability, balance deficits, transfer training, strength and mobility impairments, fall prevention, and safety awareness in order to restore functional independence, reduce fall risk, and prevent further decline. The patient and his daughter participated in the development of the physical therapy plan of care and agreed with the proposed treatment regimen. Occupational therapy evaluation further revealed that the patient currently requires modified independence to minimal assistance with basic activities of daily living and remains dependent for instrumental activities of daily living. He demonstrates decreased upper extremity strength, impaired balance, reduced activity tolerance, coordination deficits, and limitations associated with chronic left frozen shoulder, all of which negatively impact his ability to safely perform daily tasks and maintain independence. Skilled occupational therapy services are warranted to improve strength, coordination, balance, endurance, and functional performance with self-care activities while preventing further deconditioning and promoting maximum safety and independence within the home environment. Continued interdisciplinary home health services, including skilled nursing, physical therapy, and occupational therapy, are indicated to monitor medical status, reinforce education, improve functional mobility, and reduce the risk of rehospitalization and additional falls.
 Date of Order 06/14/2026 Orders Physician Face-to-Face Date: 06/09/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Parkinson's disease without dyskinesia, without mention of fluctuations <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/14/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Daniele Johnson
116 Defense Hwy Ste 400
Annapolis, MD 21401
PHONE: 4108979841 FAX: 14108979852 NPI: 1487425369

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 : 06/09/2026

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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14px;">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 Johnson, Daniele

SN Careplans

SN WK1: 2 (06/14/26-06/20/26) ,WK2: 2 (06/21/26-06/27/26) ,WK3: 1 (06/28/26-07/04/26) ,WK4: 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: 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, muscle weakness, limited strength, limited endurance, balance deficit, Pain Effect on Sleep, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises

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, * 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: TO WALK AND GET AROUND MORE

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
* 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

PT Careplans

PT WK1: 1 (06/14/26-06/20/26) ,WK2: 1 (06/21/26-06/27/26) ,WK3: 1 (06/28/26-07/04/26) ,WK5: 1 (07/12/26-07/18/26) ,WK6: 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, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair

PT Goals

PATIENT-STATED GOAL: I want to build up my strength and to be able to walk independently.

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Signature of Physician:

Date

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

Date
06/14/2026

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PROCEDURES: home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., therapeutic modalities: Apply heat to L shoulder x 20 minutes with necessary barrier and skin assessments q 5 minutes., dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., 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 - 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, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Car 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

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

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

OT Careplans

OT WK1: 1 (06/14/26-06/20/26) ,WK2: 1 (06/21/26-06/27/26) ,WK3: 1 (06/28/26-07/04/26) ,WK4: 1 (07/05/26-07/11/26) ,WK5: 1 (07/12/26-07/18/26) ,WK6: 1 (07/19/26-07/25/26) ,WK7: 1 (07/26/26-08/01/26) ,WK8: 1 (08/02/26-08/08/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, 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: Improve functional endurance : to be able to reduce the number of breaks by 50%, cough/deep breathing exercises, incentive spirometer, home exercise program: Exercises for home to strengthen the shulder, elbow and wrist, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet 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, Car Transfer - 05. Setup or clean-up assistance, 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: Improve strength, a,,mbulate outdoors

GOALS
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

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

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

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

Car Transfer - 05. Setup or clean-up assistance

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

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

Date
06/14/2026