Home Health Certification and Plan of Care

Order ID: 1150/20008

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
491012318	06/14/2026	From: 06/14/2026 To: 08/12/2026	26887	217058

6. Patient's Name and Address

Sing Allen
1314 Dartmouth Avenue,
PARKVILLE, MD 21234-
443-653-4993

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 05/26/1959 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I11.0	Hypertensive heart disease with heart failure	06/14/26

13. ICD	Other Pertinent Diagnoses	Date
I50.21	Acute systolic (congestive) heart failure	06/14/26
L89.616	Pressure-induced deep tissue damage of right heel	06/14/26
I82.401	Acute embolism and thombos unsp deep veins of r low extrem	06/14/26
I48.0	Paroxysmal atrial fibrillation	06/14/26
G20.A1	Parkinson's dis w/o dyskinesia w/o mention of fluctuations	06/14/26
F02.80	Dem in oth dis classd elswhrunsp sevw/o beh/psych/mood/anx	06/14/26
J45.998	Other asthma	06/14/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	06/14/26
M10.9	Gout unspecified	06/14/26
F41.1	Generalized anxiety disorder	06/14/26
F31.89	Other bipolar disorder	06/14/26
M13.862	Other specified arthritis left knee	06/14/26
K21.00	Gastro-esophageal reflux dis with esophagitis without bleed	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

ACETAMINOPHEN 500 MG mg by mouth every 8 hours for Pain
Atorvastatin Calcium - Atorvastatin Calcium 40 mg by mouth at bedtime for HLD
Bupropion Hydrochloride - Bupropion Hydrochloride Extended Release 150 MG tablet by mouth twice a day for Depression
Dabigatran Etexilate Mesylate 150 MG capsule by mouth twice a day for DVT
DULOXETINE HYDROCHLORIDE Delayed Release 60 MG capsule by mouth in the morning for Depression
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) MG / 1 Tablet by mouth in the morning for Anemia
Fluticasone-Salmeterol Aerosol Powder Breath Activated 100-50 MCG/ACT / 1 Inhalation by mouth once a day and evening shift for asthma
Losartan Potassium And Hydrochlorothiazide - Hydrochlorothiazide: Losartan Potassium 100-25 MG / 1 Tablet by mouth in the morning for HTN
NIFEDIPINE ER 60 MG tablet by mouth in the morning for HTN
OXYCODONE 5 MG tablet by mouth every 6 hours as needed for PAIN MANAGEMENT
PANTOPRAZOLE Delayed Release 40 MG tablet by mouth in the morning for GERD
PREGABALIN 150 MG capsule by mouth 2 times daily for Neuropathic Pain
SEROQUEL 100 mg / 1 Tablet by mouth at bedtime for Bipolar disorder
Umeclidinium Ellipta Aerosol Powder, breath activated Give 2 puff by mouth in the morning for asthma rinse mouth with water after use
Oxycontin - Oxycodone Hydrochloride ER 10 MG tablet by mouth every 12 hours for Pain for 30 Days
NALOXONE 4 MG/0.1ML / 1 spray alternating nostril Nasal as needed for Unresponsiveness Give 1 spray (4 mg/0.1ml) in nostril for unresponsiveness and/or respiratory depression related to opioid ingestion; May repeat every 2-3 minutes in alternating nostrils as needed until resident is responsive, or emergency medical assistance arrives.
Albuterol Sulfate - Albuterol Sulfate (2.5 MG/3ML) 0.083 % / 3 ml Inhale orally nebulizer every 6 hours as needed for Wheezing/SOB
MOMETASONE FUROATE External Solution 0.1 % / Apply to skin topical every 24 hours as needed for itching
TACROLIMUS External Cream 0.1 % / Apply to face topical every 24 hours as needed for Eczema
Triamcinolone Acetonide - Triamcinolone Acetonide External Cream 0.1 % / Apply to skin topical every 24 hours as needed for Itching
Lidocaine Patch - Lidocaine 4 % / Apply 1 patch to lower back transdermal once per day for Pain remove per schedule

14. DME and Supplies:

walker, wheelchair, reacher

15. Safety Measures:

wheelchair precautions, walker precautions, standard precautions, medication safety, knee precautions, fall precautions, emergency phone # clearly displayed, cardiac precautions, bleeding precautions, bathroom safety, anticoagulant precautions, ambulates with device, ambulates with assistance

16. Nutrition:

cardiac diet

17. Allergies:

codeine

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Wheelchair, 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: 1. Rarely, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, 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

patient will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive heart disease with heart failure, 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.

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

Nkiruka Obioha
2391 Greenspring Drive
Timonium, MD 21093
PHONE: 4108473000 FAX: 8554160980 NPI: 1073650024

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 **06/30/2026**: 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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Clinical Condition Requiring Homecare:

The patient is a 67-year-old male who resides alone in a single-level, first-floor apartment with six steps and a single handrail for entry. He receives intermittent assistance from his fiance, Sandy. The patient was referred to home health services following a recent hospitalization and subsequent subacute rehabilitation stay after sustaining a mechanical fall. His hospitalization was complicated by Parkinson's disease, septic arthritis of the left knee, left lower extremity deep vein thrombosis (DVT), idiopathic gout, hypertensive heart disease, congestive heart failure, and hypertension. His past medical history is also significant for acute embolism, atrial fibrillation, obstructive sleep apnea, anxiety, bipolar disorder, gastroesophageal reflux disease (GERD), and dementia. Upon skilled nursing assessment, the patient was alert and oriented and demonstrated an understanding of the plan of care. Examination of the left knee revealed drain sites that were closed with intact sutures. The incision sites were clean, dry, and left open to air, with no signs or symptoms of infection noted. There are currently no physician orders for suture removal. The patient was referred for skilled nursing, physical therapy, and occupational therapy services following discharge from the hospital and rehabilitation facility. Skilled nursing services are recommended at a frequency of one visit per week for three weeks (1W3) to monitor the patient's postoperative status, cardiopulmonary condition, medication management, safety, and overall disease progression. The next skilled nursing visit is scheduled for Thursday. Prior to hospitalization, the patient was modified independent with all functional transfers, independently ambulated with a single-point cane, independently performed activities of daily living (ADLs), and independently negotiated stairs. At the time of the physical therapy evaluation, the patient primarily utilized a wheelchair for mobility and demonstrated significant functional decline. He presented with impaired balance, evidenced by a Tinetti Balance and Gait Assessment score of 10/28, placing him at high risk for falls. Additional deficits included lower extremity weakness, impaired bed mobility, difficulty performing transfers, gait dysfunction with a rollator, and a moderate antalgic gait pattern characterized by poor left lower extremity stance time. These impairments significantly limit his functional mobility and increase his fall risk. The patient demonstrates good rehabilitation potential and is expected to benefit from skilled physical therapy interventions focused on improving strength, balance, gait mechanics, transfer ability, bed mobility, endurance, and overall functional independence while reducing fall risk. Occupational therapy evaluation revealed that prior to hospitalization the patient was independent with basic self-care activities, functional transfers, and household ambulation. Since hospitalization and rehabilitation, he has experienced decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, and decreased overall activity tolerance. These deficits have resulted in reduced independence with self-care tasks, functional transfers, and functional ambulation, limiting his ability to safely return to his prior level of function. Skilled occupational therapy services are medically necessary to address these impairments through therapeutic interventions, ADL retraining, upper extremity strengthening, balance training, energy conservation strategies, and functional mobility training to maximize safety, independence, and quality of life within the home environment. The patient remains homebound due to impaired mobility, decreased endurance, generalized weakness, and increased fall risk, requiring the continued provision of skilled home health services.
 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 Hypertensive heart disease with heart failure 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 Obioha, Nkiruka

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) ,WK4: 1 (07/05/26-07/11/26) ,WK5: 1 (07/12/26-07/18/26) ,WK6: 1 (07/19/26-07/25/26)

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), 5. Decline in mental, emotional, or behavioral status in the past 3 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, 8. Currently reports exhaustion

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; 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 ; 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

SN Goals

PATIENT-STATED GOAL: I want to walk better

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

patient/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/14/2026

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Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

N/A
Advance Directive:See MOLST for code status

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M2020 - Oral Med Management, swelling in the arms/legs, M1033 - Exhaustion, M1400 - Dyspnea, muscle spasms, poor muscle tone, muscle weakness, swelling of affected area, limited endurance, limited range of motion, limited strength, involuntary movement of extremity, balance deficit, #1 - Other - Other - Left knee - Drain sites closed with sutures to be kept clean dry and open to air. Edges well approximated. No order for suture removal.

PROCEDURES: physician-ordered wound care: #1 - Other - Other - Left knee - Drain sites closed with sutures to be kept clean dry and open to air. Edges well approximated. No order for suture removal., 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, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, 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

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) ,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) ,WK9: 1 (08/09/26-08/12/26)

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, home exercise program: Supine exercises heelslides, aps, qs, slr initially AA progress to arom, hamstring, hip flexor and gastroc, quad stretching 20 second holds on lle 4-5 reps, seated: laq eccentric knee extension, hip flexion assist as needed, hip abduction, hamstring curls, DF, PF 2-310, dynamic standing balance exercises: With ue support as needed with device work wt shifting, reaching outside bos , righting reaction, 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 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

PT Goals

PATIENT-STATED GOAL: To Improve my balance strength in my left leg and improve my walking.

GOALS
Chair to Bed to Chair - 06. Independent

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

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

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

OT Careplans

OT WK1: 1 (06/14/26-06/20/26) ,WK3: 1 (06/28/26-07/04/26) ,WK5: 1 (07/12/26-07/18/26) ,WK7: 1 (07/26/26-08/01/26) ,WK9: 1 (08/09/26-08/12/26)

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 and caregiver with all medications in the home, cough/deep breathing exercises, incentive spirometer, home exercise program: Bilateral UE triceps strengthening- w/c press-ups, triceps extensions, triceps kick backs 2-3 sets yellow and green resistance bands, equipment training, work simplification/energy conservation, transfers training: Skilled OT, transfers training, 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06.

OT Goals

PATIENT-STATED GOAL: Walk better

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/14/2026

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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, 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

Sit to Stand - 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

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
	PAGE 4 of 4
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