Home Health Certification and Plan of Care

Order ID: 1150/20026

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2EC9H57QN39	06/24/2026	From: 06/24/2026 To: 08/22/2026	7559	217058

6. Patient's Name and Address
Donald Walls
2128 Harman Avenue,
BALTIMORE, MD 21230-
410-935-5813

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 10/17/1954 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
S81.802D	Unspecified open wound left lower leg subsequent encounter	06/24/26

13. ICD	Other Pertinent Diagnoses	Date
T84.84XD	Pain due to internal orthopedic prosth dev/grft subs	06/24/26
G89.29	Other chronic pain	06/24/26
I48.91	Unspecified atrial fibrillation	06/24/26
I11.0	Hypertensive heart disease with heart failure	06/24/26
I50.32	Chronic diastolic (congestive) heart failure	06/24/26
L40.9	Psoriasis unspecified	06/24/26
E11.69	Type 2 diabetes mellitus with other specified complication	06/24/26
R80.9	Proteinuria unspecified	06/24/26
E78.00	Pure hypercholesterolemia unspecified	06/24/26
Z91.81	History of falling	06/24/26

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

Cardizem Cd - Diltiazem Hydrochloride 360 mg, Take 1 tablet by mouth once a day
Lipitor - Atorvastatin Calcium 20 mg, Take 1 tablet by mouth once a day for cholesterol and heart protection
Pradaxa - Dabigatran Etexilate Mesylate 150 mg, Take 1 capsule by mouth every 12 hours after food and with plenty of water *replaces Xarelto*
Coreg - Carvedilol 25 mg 25 mg, Take 1 tablet by mouth twice a day
Cozaar - Losartan Potassium 100 mg 100 mg, Take 1 tablet by mouth once a day nightly
Acetaminophen And Hydrocodone Bitartrate - Acetaminophen: Hydrocodone Bitartrate 325mg/7.5mg by mouth three times a day hydrocodone 7.5mg/tylenol 325mg
take 1 tablet 3x day PRN
Lasix - Furosemide 20 mg 1 tab by mouth once a day take for 14 days for swelling/Edema
Tylenol - Acetaminophen 500mg/1tab by mouth three times a day 1 tablet with hydrocodone/ylenol
Carbamide Peroxide (DEBROX) 6.5 %, Instill 5 drops into affected areas drops twice a day

14. DME and Supplies:
diabetic supplies, urinary/catheter supplies, walker, 4 wheeled walker, cane, wound care supplies

15. Safety Measures:
walker precautions, medication safety, infectious material management, fall precautions, bleeding precautions, ambulates with device, ambulates with assistance, standard precautions, bathroom safety, anticoagulant precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Dyspnea With Minimal Exertion, Ambulation

18.B. Activities Permitted
Cane, Walker

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: 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 Unspecified open wound left lower leg subsequent encounter, 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 71-year-old male who is alert and oriented with a past medical history significant for chronic back pain, venous stasis ulcer of the posterior left lower leg, bilateral lower extremity edema with blistering, atrial fibrillation, diastolic heart failure, urethral stricture requiring intermittent self-catheterization as needed, psoriasis, and tobacco use. Assessment revealed elevated blood pressure, which the patient attributed to not yet taking his prescribed antihypertensive medication. He reported chronic localized lower back pain rated 8/10 that significantly limits mobility and functional activity. Respiratory assessment demonstrated clear lung sounds bilaterally with audible upper airway congestion and intermittent wheezing; the patient reported smoking approximately one pack of cigarettes daily, and smoking cessation education was provided. Wound assessment of the posterior left lower leg revealed a venous stasis ulcer measuring approximately 4.0 cm 2.0 cm 0 cm with a mixed wound bed consisting of pink tissue at the margins, pale/white central tissue, and areas of dark purple discoloration, accompanied by moderate serosanguineous drainage without odor. Bilateral lower extremity edema and blistering were also present, although wound care was limited due to insufficient supplies in the home. The patient demonstrated significant difficulty transferring from sitting to standing because of impaired mobility and chronic back pain, warranting physical and occupational therapy evaluations. Gastrointestinal assessment was unremarkable, with the patient reporting normal bowel function. Education was provided regarding medication adherence, smoking cessation, nutrition to support cardiovascular health and wound healing, and disease management. The patient verbalized understanding, and continued skilled nursing services are indicated for ongoing wound care, medication and disease management, assessment of cardiovascular status, edema, chronic pain, impaired mobility, and monitoring for potential complications.
<o:p></o:p> Date of Order<o:p></o:p> 0<span

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/24/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Christelle Nong Libend
1701 Twin Springs Road
Halethorpe, MD 21227
PHONE: FAX: NPI: 1780096446

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 : 06/22/2026

27. Attending Physician's Signature and Date Signed **07/01/2026**: 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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style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman'; font-size:11.0000pt;mso-font-kerning:1.0000pt;">Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management dx: Unspecified open wound left lower leg subsequent encounter<span
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style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman'; font-size:11.0000pt;mso-font-kerning:1.0000pt;">Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<span
style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman';
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class="16">1 - SOC - SN Notes:<span style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman';
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style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman'; font-size:11.0000pt;mso-font-kerning:1.0000pt;"> Nong Libend, Christelle

SN Careplans

SN WK1: 2 (06/24/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26) ,WK3: 1 (07/05/26-07/11/26) ,WK4: 1 (07/12/26-07/18/26) ,WK5: 1 (07/19/26-07/25/26) ,WK6: 1 (07/26/26-08/01/26) ,WK7: 1 (08/02/26-08/08/26) ,WK8: 1 (08/09/26-08/15/26)

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 > 9

CAREGIVER: 0. No assistance needed - patient is independent or does not have needs in this area

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

patient did not have surgery- RN unable to remove this.
Advance Directive:Patient states, "If I am dead, let me go, I do not want to be on tubes." do not attempt CPR

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, cluttered/soiled living area (CM), unsafe floor coverings (CM), lack of fire safety devices (CM), M2020 - Oral Med Management, swelling in the arms/legs, M1400 - Dyspnea, dizziness/syncope, swelling in legs/around eyes, abnormal blood pressure, dependent edema, abnormal BS < 70/140 >

SN Goals

PATIENT-STATED GOAL: I want to get up and walk up the street.

GOALS
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
* 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 home enviroment has adequate fire safety devices

patient living environment has safe floor coverings

patient's living environment is clean/uncluttered

patient is adequately supervised

caregiver performs medical/rehabilitation treatments with adequate competence

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

Medication Review

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/24/2026

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mg/dL, swelling of affected area, limited endurance, Pain Interference with ADLs, balance deficit, Pain Interference with Therapy activities, Pain Effect on Sleep, #1 - Other - Posterior Left Calf - outer edges of wound- top layer of skin off, redness present, then white present and then purple area present., swell/redness surround. skin, open sores/lesions, raised bumps that are red/white, rough/scaly/cracked skin, discolored patches of skin

PROCEDURES: physician-ordered wound care: #1 - Other - Posterior Left Calf - outer edges of wound- top layer of skin off, redness present, then white present and then purple area present.: Left Lower leg- cleanse with 0.9% normal saline, If wound drainage is light to moderate use plain foam dressing. If wound drainage moderate to heavy use aqualcel or calcium alginate. cover with gauze, foam and ABD pad. apply compression (ace wrap or compression stocking) Change bandage every 1 to 3 days. If dressing is soiled prior, change dressing. For wound that is not healing follow up with Pcp with Unna boot. Monitor for signs and symptoms of infection, fever, chills, redness, malodorous and purulent drainage., physician-ordered wound care: #1 - Other - Posterior Left Calf - outer edges of wound- top layer of skin off, redness present, then white present and then purple area present.: Left Lower leg- cleanse with 0.9% normal saline, If wound drainage is light to moderate use plain foam dressing. If wound drainage moderate to heavy use aqualcel or calcium alginate. cover with gauze, foam and ABD pad. apply compression (ace wrap or compression stocking) Change bandage every 1 to 3 days. If dressing is soiled prior, change dressing. For wound that is not healing follow up with Pcp with Unna boot., Medication Review : MEDICATIONS REVIEWED WITH PATIENT/CAREGIVER., cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: Left Lower leg- cleanse with 0.9% normal saline, If wound drainage is light to moderate use plain foam dressing. If wound drainage moderate to heavy use aqualcel or calcium alginate. cover with gauze, foam and ABD pad. apply compression (ace wrap or compression stocking) Change bandage every 1 to 3 days. If dressing is soiled prior, change dressing. For wound that is not healing follow up with Pcp with Unna boot., glucose testing via monitor, coordinate/arrange for adequate fire safety devices, coordinate/arrange repair of unsafe floor coverings, coordinate/arrange for maintenance of clean/uncluttered living area

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, * 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, patient home enviroment has adequate fire safety devices, patient living environment has safe floor coverings, patient's living environment is clean/uncluttered, patient is adequately supervised, caregiver performs medical/rehabilitation treatments with adequate competence, Medication Review

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/24/2026