Home Health Certification and Plan of Care

Order ID: 1150/20100

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
AA00019132	06/26/2026	From: 06/26/2026 To: 08/24/2026	27298	217058

6. Patient's Name and Address
Raymond Haley
200 1st Avenue Apt 308,
Baltimore, MD 21227-
410-615-9787

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 11/08/1959 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
E85.4	Organ-limited amyloidosis	06/26/26

13. ICD	Other Pertinent Diagnoses	Date
I68.0	Cerebral amyloid angiopathy	06/26/26
E11.9	Type 2 diabetes mellitus without complications	06/26/26
I10.	Essential (primary) hypertension	06/26/26
R74.01	Elevation of levels of liver transaminase levels	06/26/26
F03.90	Unsp dementia unsp severity without beh/psych/mood/anx	06/26/26
E78.2	Mixed hyperlipidemia	06/26/26
F33.1	Major depressive disorder recurrent moderate	06/26/26
R91.1	Solitary pulmonary nodule	06/26/26
F17.210	Nicotine dependence cigarettes uncomplicated	06/26/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	06/26/26
Z94.4	Liver transplant status	06/26/26
Z79.4	Long term (current) use of insulin	06/26/26
Z79.82	Long term (current) use of aspirin	06/26/26

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

ASPIRIN 0 Delayed Release 81 MG / 1 Tablet by mouth in the morning FOR STROKE PREVENTION
NIFEDIPINE ER 60 MG / 1 Tablet by mouth ONCE DAILY IN THE MORNING FOR HIGH BLOOD PRESSURE
SERTRALINE 100 MG / 1 Tablet by mouth ONCE DAILY IN THE MORNING FOR DEPRESSION
ATORVASTATIN 40 MG / 1 Tablet by oral route every day at bedtime for 90 days, for stroke prevention.
NOVOLIN 70-30 FlexPen U-100 Insulin 100 unit/mL / Inject 18unit(s) by subcutaneous route twice a day for 60 days, for type 2 diabetes.

14. DME and Supplies:
cane

15. Safety Measures:
medication safety, fall precautions, diabetic precautions, ambulates with device

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
None of the above

18.B. Activities Permitted
Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: 4. Constantly, SOCIAL ISOLATION: 2. Sometimes, 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: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 8. Unknown, MOBILITY: 8. Unknown

22.B.Discharge Plans
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Organ-limited amyloidosis, 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 66-year-old White male admitted to home health services for diabetes management, medication education, and comprehensive assessment. His past medical history is significant for mixed hyperlipidemia, chronic dementia, hypertension, traumatic brain injury, recurrent cerebrovascular accidents (strokes), and other chronic comorbidities. The patient resides alone in a senior apartment with his dog, and his 12-year-old daughter <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> on weekends. Upon the Start of Care visit, the patient was alert and oriented to person, place, time, and situation (A&O 4). He complained of right wrist pain but was uncertain whether the discomfort resulted from a recent fall or from sleeping in an awkward position. The patient was instructed to apply ice to the affected area, take acetaminophen (Tylenol) as directed for pain management, and notify his healthcare provider if the pain worsened, persisted, or was associated with swelling or decreased function. He denied chest pain, shortness of breath, dizziness, lightheadedness, nausea, or vomiting. The patient reported his last bowel movement occurred the morning of the visit. Physical assessment revealed lungs clear to auscultation bilaterally, active bowel sounds in all quadrants, dry and intact skin with mild erythema noted on both arms, trace bilateral lower extremity edema, palpable peripheral pulses, and slightly delayed capillary refill. Vital signs were obtained and remained within acceptable parameters. During completion of the OASIS assessment, the patient demonstrated frustration when attempting to sign his name and was encouraged to take his time, reflecting mild cognitive and fine motor limitations. A comprehensive assessment was completed, medications were reviewed and reconciled, and the patient was admitted to home health services. The patient reports using a cane intermittently despite multiple falls and was not utilizing the assistive device during the assessment. He reported approximately three to four falls within the past two months and recurrent falls over the past several years. During one visit, he was observed returning from walking his dog without the use of his cane. Physical therapy evaluation identified right wrist pain, bilateral lower extremity weakness, impaired balance, unsteady gait, decreased safety awareness, and a significant history of recurrent falls, placing the patient at high risk for future falls and injury. These impairments negatively affect his functional mobility, transfer safety, and overall independence. The patient is considered homebound due to his history of recurrent falls, impaired balance, decreased safety awareness, and need for human assistance and an assistive device to safely leave the home. Skilled nursing education focused on diabetes management, medication compliance, recognition of signs and symptoms of hypo- and hyperglycemia, fall prevention strategies, proper use of the prescribed cane during all ambulation, skin care, and the importance of promptly reporting changes in condition, worsening pain, or additional falls to the healthcare provider. Education also reinforced home safety measures to reduce fall risk and the importance of medication adherence. The patient verbalized understanding of the teaching provided. Although skilled physical therapy was initially recommended to address lower extremity strengthening, balance deficits, gait training, transfer safety, fall prevention, and safety awareness in order to improve functional mobility and reduce the risk of further decline, the patient ultimately declined ongoing physical therapy services, stating that he felt relatively independent and did not believe additional therapy was necessary. A one-time physical therapy evaluation was completed, and the patient was discharged from physical therapy at his request after being educated on the risks associated with declining therapy, including continued falls, injury, functional decline, and potential loss of independence. The plan of care includes continued skilled nursing for ongoing assessment, diabetes management, medication education, chronic disease monitoring, reinforcement of fall prevention strategies, and surveillance for changes in functional or cognitive status, with continued encouragement to consistently use his prescribed assistive device and promptly report any additional falls or worsening symptoms.
 Date of Order 06/26/2026 Orders Physician Face-to-Face Date: 06/01/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat due to Organ-limited amyloidosis Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/26/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Alexis Cruz
3541 Washington Blvd
Halethorpe, MD 21227
PHONE: 4435439914 FAX: 14104944918 NPI: 1194306639

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 : 06/01/2026

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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home
 1 - SOC - SN Notes: soc PT Eval Notes:
 Physician Cruz, Alexis

SN Careplans

SN WK1: 1 (06/26/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26) ,WK3: 2 (07/05/26-07/11/26) ,WK4: 2 (07/12/26-07/18/26)

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: 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

HOSPITALIZATION RISKS: 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

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, D0160 - Depression, M1745 - Behavioral Issues, M2020 - Oral Med Management, D0700 - Social Isolation, M2102f - Patient Supervision, meal preparation, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, dependent edema, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, limited strength, involuntary movement of extremity, rough/scaly/cracked skin, red/tender pressure points

PROCEDURES: Medication Review: Review medication list with patient at every visit., cough/deep breathing exercises, glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule, 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: "I just want to take my meds the right way."

GOALS
patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

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

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

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

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

06/26/2026

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PT WK2: 1 (06/28/26-07/04/26)

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

PROCEDURES: gait training/stair training, transfers training, assist with fall prevention: Pt teaching provided on Falls prevention -use recomended AD at all times and/or direct assistance by CG as needed -make sure clothing does not drag on floor to create trip hazard -proper footwear, no scuffs - Strength program has been initiated for LEs, continue 1-2x/day -carry phone at all times in case of emergency -Consider medic alert button -Fall recover technique discussed -Keep stairs free of obstacles -Maintain functional pathways throughout the home and at all exits -use night lights -Advised against holding onto towel bars or soap dishes, consider grab bars, check grab bars before use -remove scatter rugs, if one must remain use double sided rug tape -Add non skid mat in the shower -keep the floor dry in the bathroom, if using a shower seat dry self completely before stepping out. Instructed pt on Fall recovery technique-Instructed pt on self assessment, if hurt to stay still and call 911. If not hurt and able to move, to slowly go up on all fours, or sit up then scoot back to the closest chair/bed then turn to a kneeling position, prop one leg and push with bilateral UE and BLE to partially stand, then pivot to sit. Other technique is to crawl or scoot to the stairs and bump up on 2nd or 3rd step then use the rail to stand up. Instructed pt to contact physician for any falls, with or without injuries. Pt VU of instructions provided via TB.

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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent

PATIENT-STATED GOAL: Just to be able to live independently

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/26/2026