Home Health Certification and Plan of Care

Order ID: 1150/20116

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3P87QU4MP38	06/27/2026	From: 06/27/2026 To: 08/25/2026	27434	217058

6. Patient's Name and Address

Paul Basenberg
1523 Marlborough Court,
Crofton, MD 21114-
443-454-1811

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 12/16/1944 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
T84.52XA	Infect/inflm reaction due to internal left hip prosth init	06/27/26

13. ICD	Other Pertinent Diagnoses	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	06/27/26
I50.22	Chronic systolic (congestive) heart failure	06/27/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/27/26
N18.2	Chronic kidney disease stage 2 (mild)	06/27/26
I48.91	Unspecified atrial fibrillation	06/27/26
I42.9	Cardiomyopathy unspecified	06/27/26
J44.9	Chronic obstructive pulmonary disease unspecified	06/27/26
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	06/27/26
D50.9	Iron deficiency anemia unspecified	06/27/26
M81.0	Age-related osteoporosis w/o current pathological fracture	06/27/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	06/27/26
Z45.2	Encounter for adjustment and management of VAD	06/27/26
Z79.2	Long term (current) use of antibiotics	06/27/26
Z79.01	Long term (current) use of anticoagulants	06/27/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	06/27/26

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

Calcium Carbonate Antacid Tablet Chewable 500 MG / 1 Tablet by mouth three times a day for acid reflux
Coq10 - Coenzyme Q10 100 MG / 1 Capsule by mouth in the morning for Supplement
Digoxin - Digoxin 125 mcg (0.125 mg) / 1 Tablet by mouth in the morning for AFib HOLD FOR APICAL HR < 60
Eliquis - Apixaban 5 MG / 1 Tablet by mouth in the morning and at bedtime for AFib
Incruse Ellipta - Umeclidinium Bromide 62.5 MCG/INH / 1 puff by mouth in the morning for COPD
Jardiance - Empagliflozin 10 MG / 1 Tablet by mouth in the morning for DIABETES
Lipitor - Atorvastatin Calcium 20 MG / 1 Tablet by mouth at bedtime for HLD
Robaxin-750 - Methocarbamol Give 1.5 tablet by mouth in the evening for MUSCLE SPASMS
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 MG / 1 Capsule by mouth in the evening for BPH
Metoprolol Succinate - Metoprolol Succinate ER 100 MG / 1 Tablet by mouth in the evening for HTN/AFIB HOLD MEDICATION IF PULSE < 60 AND/OR SYSTOLIC BLOOD PRESSURE < 110 mmHg
Metoprolol Succinate - Metoprolol Succinate ER 50 MG / 1 Tablet by mouth in the morning for HYPERTENSION /AFIB related to UNSPECIFIED ATRIAL FIBRILLATION (I48.91) HOLD MEDICATION IF PULSE < 60 AND/OR SYSTOLIC BLOOD PRESSURE < 110 mmHg
Multivitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox Tab by mouth once a day Supplemental
Daptomycin - Daptomycin 750mg by mouth once a day IV push over 5 minutes
Invanz - Ertapenem Sodium 1 gr IV intravenous once a day
Fluticasone Propionate - Fluticasone Propionate 50 mcg/actuation / 2 spray in each nostril nasal in the morning for Rhinitis ADMINISTER 2 SPRAY(S) IN EACH NOSTRIL

14. DME and Supplies:

wound care supplies, walker

15. Safety Measures:

medication safety, hip precautions, anticoagulant precautions, cardiac precautions, standard precautions, supervision at all times, transfer with assist, walker precautions, no bending, fall precautions, diabetic precautions, bleeding precautions, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

cardiac diet, diabetic, low cholesterol, low sodium

17. Allergies:

codeine olmesartan bactrim levaquin ace inhibitors artichoke

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Up As Tolerated

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: good

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

Homebound status: Due to diagnosis of Infection and inflammatory reaction due to internal left hip prosthesis, initial 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 an 81-year-old male admitted to home health services for skilled nursing management of intravenous antibiotic therapy following an infection and inflammatory reaction associated with an internal left hip prosthesis. His past medical history is significant for hypertensive heart and chronic kidney disease with congestive heart failure (CHF), type 2 diabetes mellitus (DM2), chronic kidney disease (CKD), benign prostatic hyperplasia (BPH), history of ventricular assist device (VAD), cardiomyopathy, atrial fibrillation, chronic obstructive pulmonary disease (COPD), osteoporosis, polyneuropathy, iron deficiency, and other chronic comorbidities. The patient lives alone and is considered homebound due to the considerable and taxing effort required to leave the home, as he requires a walker and one-person assistance for mobility while undergoing daily intravenous antibiotic therapy. A Start of Care (SOC) visit for intravenous infusion services was completed. The prescribed antibiotic regimen consists of ertapenem 1 gram intravenously once daily and daptomycin 750 mg intravenously once daily through 07/01/2026. The patient and family have prior experience administering home infusion therapy. During the visit, ertapenem 1 gram infusion was initiated at 12:59 PM via the right upper extremity infusion catheter. The patient received instruction on proper administration of daptomycin 750 mg via slow IV push over five minutes and expressed a preference for administering the two antibiotics separately. The patient successfully demonstrated the IV push administration technique through return demonstration, indicating understanding of proper infusion procedures. Skilled nursing reviewed the purpose,

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/27/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Mariam Khambaty
22 S Greene St
Baltimore, MD 21201
PHONE: 4102258369 FAX: 14103289106 NPI: 1124080809

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 : 06/23/2026

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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administration, dosing schedule, potential side effects, and required actions for each prescribed medication. The patient verbalized understanding of all teaching provided. On assessment, the patient denied abnormal bleeding, recent falls, urinary discomfort, or other acute complaints. He reported his last bowel movement occurred the previous day. The patient ambulates with a walker and requires assistance for safe mobility. Skin assessment revealed no open wounds. Mild erythema was noted over the left lateral posterior thigh near the affected hip, with the patient reporting intermittent tenderness at the site. Wound care orders were reviewed and include cleansing the affected area with normal saline, applying the prescribed topical medication, and leaving the area open to air. The patient was instructed to monitor for worsening redness, increased warmth, swelling, drainage, fever, or escalating pain and to promptly report these findings to the healthcare provider. Laboratory studies, including a comprehensive metabolic panel (CMP), complete blood count (CBC) with differential, erythrocyte sedimentation rate (ESR), and C-reactive protein (CRP), are scheduled to be obtained by skilled nursing on 06/29/2026 to monitor response to therapy and identify potential adverse effects of treatment. The patient is scheduled for follow-up with the Infectious Disease specialist on 07/01/2026 at 12:00 PM. Physical therapy and occupational therapy evaluations have been ordered to address mobility limitations and improve functional independence. The skilled nursing plan of care includes <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> at a frequency of 1 visit for 1 week, 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> for 1 week, followed by 1 visit weekly for 4 weeks. Continued skilled nursing services are medically necessary for intravenous antibiotic administration and education, central venous access assessment and management, laboratory specimen collection, wound assessment and care, medication management, monitoring for adverse drug reactions and signs of infection, reinforcement of patient education, and coordination of care with the Infectious Disease provider. The overall goal of care is to promote resolution of the prosthetic joint infection, prevent complications, maintain vascular access integrity, improve functional mobility, and reduce the risk of rehospitalization.
 Date of Order 06/27/2026 Orders Physician Face-to-Face Date: 06/23/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Infection and inflammatory reaction due to internal left hip prosthesis, initial encounter 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
 Physician Khambaty, Mariam

SN Careplans

SN WK1: 1 (06/27/26-06/27/26) ,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)

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: 3. Multiple hospitalizations (2 or more) in the past 6 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; 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.

Left thigh erythema cleanse with saline apply topical and leave open to air daily; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydrationLeft thigh erythema cleanse with saline apply topical and leave open to air daily
Advance Directive:Advance directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, abn cholesterol > 200 mg/dL, M1400 - Dyspnea, M1033 - Exhaustion, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, heartburn/indigestion, urine retention, limited range of motion, muscle weakness, limited strength, limited endurance, pain radiating to arms/legs, balance deficit, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit, #2 - Open

SN Goals

PATIENT-STATED GOAL: To resolve infection and increase strength

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
* 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

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/27/2026

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Wound - Other - Side of left calf - , #1 - Other - Anterior Left Thigh - Apply to left thigh erythema topically every day for wnound care apply affer cleansing with sal8pine qd and leave open to air, itchy skin, red/tender pressure points, swell/redness surround. skin

PROCEDURES: physician-ordered wound care: #1 - Other - Anterior Left Thigh - Apply to left thigh erythema topically every day for wnound care apply affer cleansing with sal8pine qd and leave open to air, cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments: Patient to self administer with assistance from daughter when needec, monitor intake & output, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired: Corrective lens applied, infusion therapy: ertapenem 1gram iv daily thru 7/1/26 & daptomycin 750mg iv daily thru 7/1/26. patient & family has completed infusion in the past. pharmacy:Continuum RX 703-935-2060(dh)

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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

06/27/2026