Home Health Certification and Plan of Care

Order ID: 1150/20481

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
9JP0KQ2XC41	07/11/2026	From: 07/11/2026 To: 09/08/2026	27832	217058

6. Patient's Name and Address
Jaime Junio
8711 Wendell Ave,
PARKVILLE, MD 21234-
443-600-2134

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 03/22/1943 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
S01.111A	Laceration w/o fb of right eyelid and periocular area init	07/11/26

13. ICD	Other Pertinent Diagnoses	Date
S60.811A	Abrasion of right wrist initial encounter	07/11/26
S80.211A	Abrasion right knee initial encounter	07/11/26
S60.512A	Abrasion of left hand initial encounter	07/11/26
I10.	Essential (primary) hypertension	07/11/26
E11.9	Type 2 diabetes mellitus without complications	07/11/26
I48.91	Unspecified atrial fibrillation	07/11/26
H33.8	Other retinal detachments	07/11/26
H35.3210	Exudative age-rel mclr degn right eye stage unspecified	07/11/26
Z91.81	History of falling	07/11/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	07/11/26

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

Atorvastatin Calcium - Atorvastatin Calcium 20 MG / 1 Tablet by mouth one time a day for H.D.
Empagliflozin 10 MG / 1 Tablet by mouth once a day for DM
LOSARTAN POTASSIUM 50 MG / 1 Tablet by mouth one time a day for HTN. Hold for SBP less than 110 and HR less than 60
Metformin Hcl - Metformin Hydrochloride Extended Release 500 MG / 1 Tablet by mouth one time a day for DM
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1.25 MG (50000 UT) / 1 Capsule by mouth one time a day every Thur for VITAMIN D DEFICIENCY for 8 Weeks
Vaseline External Gel - topical twice a day Apply to see additional directions for Abrasions unsupervised self-administration Apply vaseline and leave to open air: (R)side of face/(L) palm/(R)knee/(R)wrist
White Petrolatum External Ointment Apply to affected areas topical every 12 hours as needed for Skin irritation.

14. DME and Supplies:
None of the above

15. Safety Measures:
transfer with assist, standard precautions, medication safety, fall precautions, emergency phone # clearly displayed, diabetic precautions, bathroom safety, activity supervision

16. Nutrition:
diabetic

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance, Legally Blind, Bowel/Bladder Incontinence

18.B. Activities Permitted
Up As Tolerated

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: 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: Good

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
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Laceration without foreign body of right eyelid and periocular area, 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 83-year-old male who is alert and oriented and was referred to home health services following hospitalization and a subsequent subacute rehabilitation stay after sustaining a mechanical fall resulting in a right eyebrow/right eyelid laceration and abrasions to the right wrist and right knee. His past medical history is significant for hypertension, diabetes mellitus, atrial fibrillation, impaired vision secondary to retinal detachment, and recurrent falls. The patient resides in a one-story home with his wife, stepdaughter, and other family members, who provide assistance and supervision as needed. The home has eight steps at the entrance with a handrail. The patient's stepdaughter was present during the Skilled Nursing assessment. The patient reports occasional urinary incontinence, denies pain, and does not routinely use an assistive device for ambulation. Assessment revealed the right eyebrow/right eyelid laceration to be closed with sutures, with wound edges well approximated and no evidence of infection or other complications. Sutures are scheduled to be removed by a plastic surgeon. The patient has significant visual impairment, being blind in the left eye with severely limited vision in the right eye due to a history of retinal detachment. During the Physical Therapy evaluation, the patient inaccurately identified the number of fingers presented, confirming impaired vision. According to the caregiver, vision in the right eye is approximately 5%, although the patient reports that he is able to see adequately. Prior to hospitalization, the patient ambulated without an assistive device, required family assistance with showering and stair negotiation, and was independent with transfers. At the time of the Physical Therapy evaluation, the patient demonstrated impaired balance and functional mobility, evidenced by a Tinetti Balance and Gait Assessment score of 17/28 and a Timed Up and Go (TUG) time of 17 seconds, indicating an increased risk for falls. He ambulated approximately 80 feet throughout the home without an assistive device, demonstrating mild unsteadiness without loss of balance. The patient required contact guard assistance to negotiate eight entrance steps using a single handrail and demonstrated minor difficulty with transfers while remaining independent with bed mobility. Bilateral lower extremity weakness, impaired balance, visual deficits, and recent fall history contribute to his elevated fall risk and functional limitations. The patient demonstrates good rehabilitation potential and is expected to achieve therapy goals with continued intervention. Skilled Nursing services have been initiated with a recommended frequency of one visit weekly for three weeks (1W3), with the next Skilled Nursing visit scheduled for Wednesday. Physical Therapy and Occupational Therapy evaluations have been ordered as part of the interdisciplinary plan of care. Skilled Nursing will continue to monitor wound healing, assess for signs and symptoms of infection or complications, evaluate the patient's overall health status and safety, reinforce medication compliance and disease process management for hypertension, diabetes mellitus, and atrial fibrillation, and provide ongoing patient and caregiver education regarding fall prevention, home safety, visual impairment precautions, skin integrity, proper nutrition and hydration, and the importance of attending scheduled follow-up appointments. Skilled Physical Therapy will focus on improving strength, balance, gait, stair negotiation, transfer ability, and overall functional mobility to maximize safety, reduce fall risk, and facilitate the patient's return to his prior level of function.
 Date of Order 07/11/2026 Orders Physician Face-to-Face Date: 07/03/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat s due to Laceration without foreign body of right eyelid and periocular area, 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 PT Eval Notes:
 <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/11/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Erika Yeung
2800 Sollers Point Rd
Dundalk, MD 21222
PHONE: 4103916996 FAX: 14106876877 NPI: 1821973314

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 : 07/03/2026

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;">Physician Yeung, Erika

SN Careplans

SN WK1: 1 (07/11/26-07/11/26) ,WK2: 1 (07/12/26-07/18/26) ,WK3: 1 (07/19/26-07/25/26) ,WK4: 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: 2. Non-agency caregiver(s) need training/supportive services to 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, 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; 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.

N/A
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, M1610 - Urinary Incontinence, poor muscle tone, muscle weakness, limited endurance, limited strength, B1000 - Vision Deficit, open sores/lesions, #1 - Laceration - Other - Right eyebrow - Laceration closed with sutures to be removed by plastic surgeon. Keep clean dry and open to air.

PROCEDURES: physician-ordered wound care: #1 - Laceration - Other - Right eyebrow - Laceration closed with sutures to be removed by plastic surgeon. Keep clean dry and open to air., train caregiver(s) to perform medical/rehabilitation treatments, bladder training, teach/coordinate/arrange medication packaging and/or administration

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, * urinary incontinence management including bladder training Kegel exercises skin care, 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, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: No more falls

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

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
* 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

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

patient is adequately supervised

caregiver administers and/or packages medications appropriately

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	07/11/2026

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PT Careplans

PT WK2: 1 (07/12/26-07/18/26) ,WK3: 1 (07/19/26-07/25/26) ,WK4: 1 (07/26/26-08/01/26) ,WK5: 1 (08/02/26-08/08/26) ,WK6: 1 (08/09/26-08/15/26) ,WK7: 1 (08/16/26-08/22/26) ,WK8: 1 (08/23/26-08/29/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170O1 - 12 Steps, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper 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: Medication management : Review medication with caregiver, home exercise program: Laq, hip flexion, hip abduction, heel raises, df, aps,, equipment training, work simplification/energy conservation, dynamic standing balance exercises: Work dynamic balance training exercises to improve pts hip ankle step strategies, 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 - 05. Setup or clean-up assistance, 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 - 03. Partial/moderate assistance, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: To improve my leg strength and balance to reduce risk for falls

GOALS
Chair to Bed to Chair - 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

Toilet Transfer - 05. Setup or clean-up assistance

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 - 03. Partial/moderate assistance

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/11/2026