Home Health Certification and Plan of Care

Order ID: 1150/20545

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
49344746	07/14/2026	From: 07/14/2026 To: 09/11/2026	28077	217058

6. Patient's Name and Address
Terry McDowell
7306 Parkway Drive Unit 132,
HANOVER, MD 21076-
984-281-8206

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 10/03/1983 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
L03.116	Cellulitis of left lower limb	07/14/26

13. ICD	Other Pertinent Diagnoses	Date
E11.621	Type 2 diabetes mellitus with foot ulcer	07/14/26
L97.521	Non-prs chronic ulcer oth prt l foot limited to brkdwn skin	07/14/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	07/14/26
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	07/14/26
I10.	Essential (primary) hypertension	07/14/26
E78.5	Hyperlipidemia unspecified	07/14/26
F17.210	Nicotine dependence cigarettes uncomplicated	07/14/26
Z89.422	Acquired absence of other left toe(s)	07/14/26
Z79.4	Long term (current) use of insulin	07/14/26
Z79.82	Long term (current) use of aspirin	07/14/26

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

OXYCODONE 10mg; by mouth as necessary PRN every 6-8 hours as needed for pain
Metformin - Metformin Hydrochloride 1000mg; 1 tab by mouth twice a day DM
ASPIRIN 81 mg Oral 1X daily prophylactic
DULOXETINE HYDROCHLORIDE 30 mg 30mg; 1 tab Oral twice a day neuropathy
GABAPENTIN 300 mg 300mg; 3 tabs Oral 3X daily neuropathy
ATORVASTATIN 80 mg Oral 1X daily CHOLESTEROL

14. DME and Supplies:
diabetic supplies, walker, wound care supplies, cane, KNEE SCOOTER

15. Safety Measures:
standard precautions, fall precautions, diabetic precautions, bleeding precautions, walker precautions, medication safety, transfer with assist, sharps precautions

16. Nutrition:
diabetic

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation, Amputation

18.B. Activities Permitted
Cane, Walker, Exercises Prescribed, SOF T BRACE ON LLE

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: 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 Cellulitis of left lower limb, 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 42-year-old male admitted to home health services following hospitalization on 07/07/2026 for worsening non-healing left foot wounds with recurrent osteomyelitis. During hospitalization, the patient underwent surgical debridement and a left transmetatarsal amputation with a plantar flap and was treated with intravenous vancomycin and ceftriaxone before discharge. His past medical history is significant for type 2 diabetes mellitus, hypertension, hyperlipidemia, peripheral arterial disease, diabetic neuropathy, tobacco and cocaine use, history of left toe amputation secondary to osteomyelitis, history of partial fourth and fifth ray amputations, and a prior episode of clavicular osteomyelitis. Previous arterial Doppler studies performed on 03/23/2026 demonstrated normal resting arterial perfusion of both feet. The patient currently resides in a ground-level hotel with his girlfriend, who assists with his care as needed while working during the day. He reports no falls within the past year and is scheduled for follow-up with his primary care provider, Dr. Tun. The patient is alert and oriented 3 and is able to communicate his needs appropriately. Vital signs are stable. He reports left foot pain ranging from 3/10 to 6/10, which is managed with prescribed oxycodone. Finger-stick blood glucose readings range from 140 to 180 mg/dL. The patient denies shortness of breath, lung sounds are clear throughout, appetite is good, and his last bowel movement occurred today. Comprehensive skilled nursing assessment revealed a healing left transmetatarsal amputation with a plantar flap measuring approximately 5.0 cm 6.0 cm. The left lower extremity surgical wound contains staples with an open area along the lateral aspect of the foot and a plantar flap requiring ongoing wound management. New wound care orders include Aquacel Ag dressing changes every three days. Wound care orders were reviewed, and skilled nursing is scheduled at a frequency of two <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> per week for six weeks to provide wound assessment, dressing changes, infection surveillance, and ongoing monitoring for healing and complications. Medication reconciliation and comprehensive medication review were completed. Education was provided regarding all prescribed medications, including dosage, frequency, purpose, and potential side effects. The patient was instructed on proper wound care techniques, signs and symptoms requiring immediate notification of the registered nurse or physician, and the relationship between diabetes management and wound healing. Education emphasized maintaining blood glucose control, medication adherence, proper nutrition, infection prevention, and monitoring for increased redness, swelling, drainage, foul odor, fever, or worsening pain. The patient was receptive to all teaching and verbalized understanding. Physical therapy evaluation identified left foot pain, decreased lower extremity strength, impaired balance, decreased functional mobility, inability to ambulate due to non-weight-bearing status of the left lower extremity, impaired transfers, decreased safety awareness, and an increased risk for falls. The patient primarily mobilizes using a knee scooter and occasionally hops with a walker while maintaining non-weight-bearing precautions. Skilled physical therapy is medically necessary to improve strength, transfers, balance, functional mobility, safety awareness, and mobility with appropriate assistive devices to reduce fall risk and restore the patient's highest level of independence. The established physical therapy plan of care includes treatment twice weekly for two weeks followed by once weekly for four weeks, and the patient is in agreement with the plan of care. Occupational therapy evaluation determined that the patient requires minimal assistance to standby assistance for basic activities of daily living and is dependent for instrumental activities of daily living. Skilled occupational therapy is medically necessary to improve activity tolerance, maximize independence with activities of daily living, enhance safety while maintaining non-weight-bearing precautions, and improve overall quality of life. The patient is considered homebound due to the diagnosis of left transmetatarsal amputation, non-weight-bearing status of the left lower extremity, impaired mobility, decreased balance, and the need for human assistance and assistive devices, including a walker, knee scooter, or crutches, to leave the home safely. Leaving the home requires considerable and taxing effort and places the patient at increased risk for falls and further injury. Continued skilled nursing, physical therapy, and occupational therapy services are medically necessary to promote wound healing, prevent infection and further complications, improve functional mobility and independence, reinforce diabetic management and safety education, and reduce the risk of rehospitalization.
 Date of Order <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/14/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Zaw Tun
7070 Samuel Morse Dr
Columbia, MD 21046
PHONE: 800-777-7904 FAX: NPI: 1346587060

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 : 07/12/2026

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;">07/14/2026 Orders Physician Face-to-Face Date: 07/12/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Cellulitis of left lower limb 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 Tun, Zaw

SN Careplans

SN WK1: 2 (07/14/26-07/18/26) ,WK2: 2 (07/19/26-07/25/26) ,WK3: 2 (07/26/26-08/01/26) ,WK4: 2 (08/02/26-08/08/26) ,WK5: 2 (08/09/26-08/15/26) ,WK6: 2 (08/16/26-08/22/26)

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, 4. Multiple emergency department visits (2 or more) in the past 6 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, 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; 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: M2020 - Oral Med Management, meal preparation, dependent edema, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, swelling of affected area, limited strength, limited endurance, balance deficit, Pain Effect on Sleep, Pain Interference with ADLs, bleeding/discharge at site, #1 - Other - Other - PLANTAR ASPECT OF LEFT FOOT - FLAP, #2 - Observable Surgical Wound - Other - LATERAL ASPECT OF LEFT FOOT - SCANT AMOUNT OF YELLOW SLOUGH NOTED

PROCEDURES: physician-ordered wound care: #1 - Other - Other - PLANTAR ASPECT OF LEFT FOOT - FLAP: SN/PT/CG TO COVER WITH DRY GAUZE WITH EACH DRESSING CHANGE., physician-ordered wound care: #2 - Observable Surgical Wound - Other - LATERAL ASPECT OF LEFT FOOT - SCANT AMOUNT OF YELLOW SLOUGH NOTED: SN/PT/CG TO CLEANSE LEFT LATERAL FOOT WOUND WITH NSS OR VASHE CLEANSER, LOOSELY PACK WITH AQUACEL AG, COVER WITH 4X4 GAUZE, WRAP WITH KERLIX, SECURE WITH ACE WRAP EVERY 3 DAYS, CHANGE PRN FOR SOILED DRESSING., glucose testing via monitor: PATIENT TO MONITOR BLOOD GLUCOSE LEVELS DAILY.

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

SN Goals

PATIENT-STATED GOAL: NOT TO LOSE MY FOOT

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

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/14/2026

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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, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 2 (07/14/26-07/18/26) ,WK2: 2 (07/19/26-07/25/26) ,WK3: 1 (07/26/26-08/01/26) ,WK4: 1 (08/02/26-08/08/26) ,WK5: 1 (08/09/26-08/15/26) ,WK6: 1 (08/16/26-08/22/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, 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, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair

PROCEDURES: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR Seated-LAQ hip flex, hip abd, pillow squeeze. Standing- RMini squat, R heel/toe raise, L hip flex, L hip abd, L hip ext, L leg curls., equipment training: Rollator, walker and possibly crutches, gait training on uneven surfaces: With Rollator, walker and possibly crutches, gait training/stair training: With Rollator, walker and possibly crutches, transfers training

TEACH PATIENT/CAREGIVER: * 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. 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 - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: I want to be able to gain mobility, strength, get my foot back

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Eating - 06. Independent

OT Careplans

OT WK1: 1 (07/14/26-07/18/26) ,WK2: 1 (07/19/26-07/25/26) ,WK3: 1 (07/26/26-08/01/26) ,WK4: 1 (08/02/26-08/08/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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 : med list updates, Improve UE strength : Improve UE strength to 4++, Improve functional endurance : To reduce breaks by 50%, Improve standing endurance : To able to stand on both legs, cough/deep breathing exercises, incentive spirometer, home exercise program: Exe for sh, elbow and wrist, equipment training, work simplification/energy conservation

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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: return to PLOF I in ADLs

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
07/14/2026