Home Health Certification and Plan of Care

Order ID: 1150/20522

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
57229462	07/14/2026	From: 07/14/2026 To: 09/11/2026	23677	217058

6. Patient's Name and Address

Ronald Kessler
319 Camrose Ave,
BROOKLYN, MD 21225-
443-527-7751

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 07/19/1943 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
L03.317	Cellulitis of buttock	07/14/26

13. ICD	Other Pertinent Diagnoses	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	07/14/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	07/14/26
N18.32	Chronic kidney disease stage 3b	07/14/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	07/14/26
G93.41	Metabolic encephalopathy	07/14/26
M75.102	Unsp rotatr-cuff tear/ruptr of left shoulder not trauma	07/14/26
J44.89	Other specified chronic obstructive pulmonary disease	07/14/26
I69.354	Hemiplga following cerebral infrc affecting left nondom side	07/14/26
I48.0	Paroxysmal atrial fibrillation	07/14/26
E11.65	Type 2 diabetes mellitus with hyperglycemia	07/14/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	07/14/26
M10.9	Gout unspecified	07/14/26
I95.1	Orthostatic hypotension	07/14/26
F33.8	Other recurrent depressive disorders	07/14/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	07/14/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	07/14/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/14/26
F41.9	Anxiety disorder unspecified	07/14/26
H40.89	Other specified glaucoma	07/14/26
E78.49	Other hyperlipidemia	07/14/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	07/14/26
Z79.4	Long term (current) use of insulin	07/14/26
Z79.51	Long term (current) use of inhaled steroids	07/14/26
Z79.01	Long term (current) use of anticoagulants	07/14/26

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

Acetaminophen - Acetaminophen 500 MG by mouth every 6 hours Give 2 tablet by mouth every 6 hours as needed for Pain 1-3
Aspirin - Aspirin 81mg by mouth once a day Give 1 tablet by mouth one time a day for CVA Prophylaxis Take 81 mg by mouth daily.
Atorvastatin Calcium - Atorvastatin Calcium 40mg by mouth once a day Give 1 tablet by mouth one time a day for Hyperlipidemia Take 40 mg by mouth nightly.
Gabapentin - Gabapentin 300 mg by mouth twice a day Give 1 capsule by mouth two times a day for Neuropathic pain Take 300 mg by mouth 2 times daily.
Mirtazapine - Mirtazapine 7.5 mg by mouth in the evening Give 1 tablet by mouth in the evening for Depression Take 1 tablet by mouth nightly
Cozaar - Losartan Potassium 50 mg 1 tablet by mouth once a day
Buspirone Hcl - Buspirone Hydrochloride 10mg=1tablet by mouth three times a day Give 1 tablet by mouth every 8 hours for Anxiety Take 1 tablet by mouth 3 times daily.
Famotidine - Famotidine 20 mg 20mg=1tablet by mouth once a day
Eliquis - Apixaban 5mg=1tablet by mouth twice a day Take 0.5 5ablets 2x daily
Xigduo Xr - Dapagliflozin Propanediol: Metformin Hydrochloride 5mg=1tablet by mouth once a day
Latanoprost - Latanoprost 0.005% left eye in the evening Instill 1 drop in left eye in the evening for Glaucoma Place 1 drop into the left eye nightly.
Dorzolamide Hydrochloride - Dorzolamide Hydrochloride eq 2 perc base right eye three times a day Instill 1 drop in right eye two times a day for Glaucoma Place 1 drop into the right eye 3 times daily.
Insulin - Insulin Pork 100units/ml subcutaneous before meal Inject as per sliding scale: if 0 - 150 = 0; 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10 Greater than 400, give 12 units then call MD, subcutaneously before meals for DM
Insulin - Insulin Pork 15units subcutaneous at bedtime Inject 15 unit subcutaneously at bedtime for DM

14. DME and Supplies:

wound care supplies, walker, diabetic supplies, bath bench

15. Safety Measures:

standard precautions, fall precautions, diabetic precautions, medication safety, walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with device

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

iodine

18.A. Functional Limitations

Endurance, Bowel/Bladder Incontinence, Ambulation

18.B. Activities Permitted

Transfer bed/Chair, Walker, Exercises Prescribed, 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: Yes

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

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Cellulitis of buttock, 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 82-year-old male readmitted to home health services following a recent hospitalization for sepsis with subsequent partial amputation of the left great toe. His past medical history is significant for coronary artery disease status post coronary artery bypass graft (CABG), atrial fibrillation, type 2 diabetes mellitus, chronic kidney disease stage III, hypertension, and cerebrovascular accident. The patient resides with his daughter, who serves as his primary caregiver and is available throughout the day while working from home. His grandson also assists with his care as needed. The patient lives in a single-family home with five steps at the entrance but remains on the main level of the home. He was evaluated by his primary care provider, Dr. Chase, on 07/13, and per discharge instructions, has no weight-bearing restrictions to the left lower extremity but was instructed to weight bear on the left heel during ambulation. The patient reports no falls within the past two months but has experienced approximately three to four falls over the past year. The patient is alert and oriented 3, able to communicate his needs appropriately, and ambulates with a walker. Vital signs were obtained and are within normal limits. A comprehensive skilled nursing assessment was completed. The surgical site to the left great toe was assessed and noted to be clean, dry, and intact without signs or symptoms of infection, including no increased redness, warmth, swelling, purulent drainage, or foul odor. The patient also has a small abscess on the right buttock

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

Shanita Chase
1701 Twin Springs Rd
Baltimore, MD 21227
PHONE: 410-737-5000 FAX: 14107375401 NPI: 1487650891

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 : 06/13/2026

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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that was assessed and showed no evidence of infection. Wound care orders for both the left great toe surgical site and the right buttock wound are pending from the provider. The provider has been notified, and skilled nursing will initiate wound care upon receipt of physician orders. Medication reconciliation was completed with no discrepancies identified. Education was provided to the patient and caregiver regarding diabetes management, including routine blood glucose monitoring, adherence to a diabetic diet, medication compliance, and the importance of maintaining glycemic control to promote optimal wound healing. Additional education focused on infection prevention through proper hand hygiene, routine wound monitoring, recognition of signs and symptoms of infection, and prompt notification of the healthcare provider for increased redness, swelling, warmth, drainage, fever, or worsening pain. Medication management education reinforced medication adherence, understanding medication indications, and reporting adverse effects or concerns. Fall prevention education emphasized consistent use of the walker, removal of household hazards, maintaining adequate lighting, proper footwear, and requesting assistance with mobility when needed. The patient and caregiver verbalized understanding of all teaching provided. Physical therapy assessment identified left lower extremity pain, decreased bilateral lower extremity strength, impaired functional mobility, difficulty negotiating stairs, unsteady gait, impaired balance, difficulty with transfers, decreased safety awareness, and a history of recurrent falls, placing the patient at increased risk for future falls and functional decline. Skilled home physical therapy is medically necessary to improve lower extremity strength, gait quality, balance, transfer ability, stair negotiation, safety awareness, and overall functional mobility to restore the patient's highest level of independence within the home. The physical therapy plan of care includes treatment frequency of 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> per week for 2 weeks followed by 1 visit per week for 7 weeks, with the patient and primary caregiver in agreement with the established plan of care. The patient is considered homebound due to the diagnosis of left great toe amputation, unsteady gait, impaired balance, history of frequent falls, and the need for human assistance and a walker for all community mobility. Leaving the home requires considerable and taxing effort and poses a significant safety risk. Continued skilled nursing services remain medically necessary for ongoing postoperative assessment, wound monitoring and management upon receipt of physician orders, medication management, chronic disease education, infection prevention, and reinforcement of safety measures to promote wound healing, prevent complications, reduce fall risk, and avoid rehospitalization.
 Date of Order 07/14/2026 Orders Physician Face-to-Face Date: 06/13/2026 Clinical Condition Requiring Home Care per Certifying Physician: pt-eval & treat due to Cellulitis of buttock 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 - PT Notes: soc PT Eval Notes:
 Physician Chase, Shanita

SN Careplans

SN 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) ,WK5: 1 (08/09/26-08/15/26) ,WK6: 1 (08/16/26-08/22/26) ,WK7: 1 (08/23/26-08/29/26)

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), 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: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, M1610 - Urinary Incontinence, limited endurance, limited strength, B1000 - Vision Deficit,

SN Goals

PATIENT-STATED GOAL: Patient stated he would like to regain 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
* 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
* 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

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

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balance deficit, #1 - Observable Surgical Wound - Other - Left great toe - , #2 - Other - Other - Right buttocks - , open sores/lesions

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - Left great toe -: Cleanse wound with wound cleaner and pat dry leave OTA, physician-ordered wound care: #2 - Other - Other - Right buttocks -: Cleanse wound with wound cleaner and pat dry apply alginate and cover with dry dressing every other day and as-needed for soiled dressing, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately

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) ,WK7: 1 (08/23/26-08/29/26) ,WK8: 1 (08/30/26-09/05/26) ,WK9: 1 (09/06/26-09/11/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170P1 - Picking Up Object, 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, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170D1 - Sit to Stand, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer

PROCEDURES: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ, hip flex, hip abd, pillow squeeze. Standing-Mini squat, hip flex, hip abd, hip ext, leg curls., equipment training: Walker, work simplification/energy conservation, dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training/stair training, transfers training

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 - 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

PT Goals

PATIENT-STATED GOAL: I want to be able to walk better

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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