Home Health Certification and Plan of Care

Order ID: 1150/19443

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3JE9D57CE45	06/01/2026	From: 06/01/2026 To: 07/30/2026	26322	217058

6. Patient's Name and Address

Bruce Moore
514 Old Orchard Road,
BALTIMORE, MD 21229-
443-980-0172

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 03/24/1944 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I11.0	Hypertensive heart disease with heart failure	06/01/26

13. ICD	Other Pertinent Diagnoses	Date
I50.23	Acute on chronic systolic (congestive) heart failure	06/01/26
I48.0	Paroxysmal atrial fibrillation	06/01/26
I44.2	Atrioventricular block complete	06/01/26
N40.1	Benign prostatic hyperplasia with lower urinary tract symp	06/01/26
R33.8	Other retention of urine	06/01/26
E78.5	Hyperlipidemia unspecified	06/01/26
K59.00	Constipation unspecified	06/01/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	06/01/26
Z79.01	Long term (current) use of anticoagulants	06/01/26
Z95.810	Presence of automatic (implantable) cardiac defibrillator	06/01/26
Z87.891	Personal history of nicotine dependence	06/01/26

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

Atorvastatin Calcium - Atorvastatin Calcium 40 mg / 1 Tablet by mouth at bedtime for hyperlipidemia
Dapagliflozin Propanediol 10 mg / 1 Tablet by mouth once a day for Heart failure
Eliquis - Apixaban 5 mg / 1 Tablet by mouth every 12 hours for CVA prophylaxis
Magnesium Oxide - Simethicone 400 mg / 1 Tablet by mouth every 12 hours for supplement
Metoprolol Succinate - Metoprolol Succinate Extended Release 24 Hour 25 MG / 1 Tablet by mouth once a day for HTN HOLD FOR SBP<110 OR HR<60
Sacubitril-Valsartan 24-26 mg/tablet / Give 0.5 tablet by mouth every 12 hours for afib
Spironolactone - Spironolactone 25 mg/tablet / Give 0.5 tablet by mouth once a day for EDEMA
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg / 1 Capsule by mouth at bedtime for BPH
Tylenol - Acetaminophen 325 mg/tablet / Give 2 tablet by mouth every 6 hours as needed for pain give 2 tablets to equal 650mg NTE 3G/24HOURS
Furosemide - Furosemide 20 mg / 1 Tablet by mouth once a day for CHF, only on sun, Tues, Thurs and sat

14. DME and Supplies:

bath bench, walker

15. Safety Measures:

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

16. Nutrition:

cardiac diet

17. Allergies:

shrimp

18.A. Functional Limitations

Endurance, Ambulation, Bowel/Bladder Incontinence

18.B. Activities Permitted

Transfer bed/Chair, Exercises Prescribed, 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: Yes

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

SN: family/caregiver will be responsible for managing treatment
PT: family/caregiver will be responsible for managing treatment
OT: patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive heart disease with heart failure, 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:

Patient is an 82-year-old male admitted to home health services following a recent stay at a skilled nursing facility and hospitalization for a congestive heart failure (CHF) exacerbation. His past medical history is significant for depression, malignant neoplasm of the prostate, Type 2 diabetes mellitus, unspecified protein-calorie malnutrition, hyperlipidemia, dementia of unspecified severity, anxiety disorder, hypertension, atrial fibrillation, chronic obstructive pulmonary disease (COPD), peripheral vascular disease, congestive heart failure, urinary retention, and muscle wasting. Upon Start of Care assessment, the patient was alert and oriented to person, place, and time, with vital signs initially within normal limits. He resides with his spouse in a two-story home with a first-floor living setup and receives additional assistance from his daughter, caregivers, and family support system. The home is equipped with a stairlift, and the patient occasionally accesses the second floor for showering. Comprehensive nursing assessment and medication reconciliation were completed. Patient and caregivers received extensive education regarding medication management, including medication purpose, dosage, administration schedule, potential side effects, and the importance of adherence to the prescribed treatment regimen. Additional teaching focused on management of chronic disease processes, recognition of worsening CHF and COPD symptoms, proper nutrition and hydration to address malnutrition risk, urinary retention management, infection prevention strategies, and indications for physician notification regarding changes in condition. Fall prevention and home safety education were reinforced, including proper use of assistive devices, maintaining uncluttered walkways, ensuring adequate lighting, wearing appropriate footwear, and utilizing caregiver assistance during mobility tasks. Patient and caregivers verbalized understanding of all instructions provided. Physical therapy evaluation revealed a significant decline in functional mobility compared to prior level of function. Prior to hospitalization, the patient reported ambulating independently indoors without an assistive device and occasionally using a single-point cane. At the time of evaluation, he demonstrated generalized weakness with bilateral lower extremity strength assessed at 3/5 by manual muscle testing. The patient required contact guard assistance for transfers and short-distance ambulation without an assistive device and exhibited a slow gait cadence, delayed response time, impaired balance, and decreased overall mobility. These deficits place him at an increased risk for falls and functional decline. Skilled physical therapy services were deemed medically necessary to improve strength, balance, safety awareness, endurance, and overall independence with functional mobility in an effort to return the patient to his prior level of function. Occupational therapy evaluation found that the patient is currently independent with basic grooming, dressing, and bathing tasks; however, he continues to require monitoring and support for safety due to weakness, impaired mobility, and chronic medical conditions. During the evaluation, the patient was noted to have hypotension with a blood pressure reading of 80/50 mmHg, although he denied dizziness, lightheadedness, or other associated symptoms. The primary care physician, Dr. Esther Khan, was notified, and a message was left regarding the patient's blood pressure status. Review of the medication profile indicated that metoprolol should be withheld if systolic blood pressure is below 110 mmHg. A family friend present during the visit reported that the caregiver prepares the patient's medication box and indicated that metoprolol may have been administered despite the low blood pressure parameter. The patient's daughter, Cayn, was contacted and was unaware of the situation. She stated that the family would obtain a blood pressure monitor as soon as possible to facilitate ongoing blood pressure monitoring in the home. The patient and family were instructed to seek emergency medical assistance by calling 911 if symptoms such as dizziness, weakness, syncope, or altered mental status develop. Increased fluid intake was encouraged as appropriate. Occupational therapy services were recommended every other week throughout the episode of care to address activities of daily living training, functional mobility training, therapeutic exercises, home exercise program development, safety education, and caregiver training. At this time, the patient remains homebound due to generalized weakness, impaired mobility,

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/01/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Esther Cahn
515 Fairmount Ave
Towson, MD 21286
PHONE: 410-296-5300 FAX: 14105842251 NPI: 1023893815

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 : 05/18/2026

27. Attending Physician's Signature and Date Signed **07/08/2026** 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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decreased endurance, fall risk, and the need for assistance with leaving the home safely. Skilled nursing services remain necessary for ongoing cardiopulmonary assessment, medication management and education, disease process monitoring, nutritional status evaluation, blood pressure monitoring, safety assessments, fall prevention interventions, and caregiver support. Continued interdisciplinary home health services, including skilled nursing, physical therapy, and occupational therapy, are indicated to prevent rehospitalization, maximize functional independence, ensure medication and disease management compliance, and promote optimal health and safety outcomes.
 Date of Order 06/01/2026 Orders Physician Face-to-Face Date: 05/18/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Hypertensive heart disease with heart failure 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 Cahn, Esther

SN Careplans

SN WK1: 1 (06/01/26-06/06/26) ,WK2: 1 (06/07/26-06/13/26) ,WK3: 1 (06/14/26-06/20/26) ,WK4: 1 (06/21/26-06/27/26) ,WK5: 1 (06/28/26-07/04/26) ,WK6: 1 (07/05/26-07/11/26)

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: 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, Home Safety, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, M1400 - Dyspnea, M1610 - Urinary Incontinence, limited strength, limited endurance, muscle weakness, Pain Interference with ADLs, Pain Interference with Therapy activities, B0200 - Hearing Deficit, balance deficit, weak hand grips

PROCEDURES: monitor intake & output, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange for maintenance of clean/uncluttered living area, coordinate/arrange home modifications for hearing impaired, i.e. alarms

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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 hearing-impaired including installing special fire-detector/CO2 alarms, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related

SN Goals

PATIENT-STATED GOAL: Patient stated she would like to remain free of fall and 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
* 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
* 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
* 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 hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

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

patient's transportation needs are met

patient's living environment is clean/uncluttered

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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medication(s) purpose, schedule, patient's transportation needs are met, patient's living environment is clean/uncluttered, 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 WK1: 1 (05/31/26-06/06/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170M1 - 1 - Step (curb), GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, GG0170I1 - Walk 10 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed, gait training/stair training: Ambulation indoors and outdoors, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, 1 - Step (curb) - 02. Substantial/maximal assistance, 12 Steps - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Car Transfer - 05. Setup or clean-up assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

PT Goals

PATIENT-STATED GOAL: To be able to walk safely

GOALS
Toilet Transfer - 06. Independent

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

1 - Step (curb) - 02. Substantial/maximal assistance

12 Steps - 02. Substantial/maximal assistance

4 Steps - 02. Substantial/maximal assistance

Car Transfer - 05. Setup or clean-up assistance

Picking Up Object - 02. Substantial/maximal assistance

Walk 10 Feet - 02. Substantial/maximal assistance

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Walk 150 Feet - 02. Substantial/maximal assistance

Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

OT Careplans

OT WK2: 1 (06/07/26-06/13/26) ,WK4: 1 (06/21/26-06/27/26) ,WK6: 1 (07/05/26-07/11/26) ,WK8: 1 (07/19/26-07/25/26)

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: cough/deep breathing exercises, home exercise program: 16 oz water bottle:bilateral shoulder flex, chest presses, horizontal abd/add, bicep curls 2x10 reps, equipment training, work simplification/energy conservation, dynamic standing balance exercises: As tolerated, dynamic standing balance exercises: As tolerated, transfers training

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, 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, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: to get stronger

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

Shower/Bathe Self - 05. Setup or clean-up assistance

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

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

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:	Date
Electronically Signed by Messick, Charles RN	06/01/2026

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