Home Health Certification and Plan of Care

Order ID: 1150/20557

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
51254961	07/12/2026	From: 07/12/2026 To: 09/09/2026	27929	217058

6. Patient's Name and Address

Ming Zheng
3670 Falls Road,
Hampden, MD 21211-
410-353-6338

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 10/02/1978 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
K70.9	Alcoholic liver disease unspecified	07/12/26

13. ICD	Other Pertinent Diagnoses	Date
D61.818	Other pancytopenia	07/12/26
F10.131	Alcohol abuse with withdrawal delirium	07/12/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	07/12/26
I50.22	Chronic systolic (congestive) heart failure	07/12/26
N18.4	Chronic kidney disease stage 4 (severe)	07/12/26
N17.9	Acute kidney failure unspecified	07/12/26
D63.1	Anemia in chronic kidney disease	07/12/26
D53.9	Nutritional anemia unspecified	07/12/26
B18.1	Chronic viral hepatitis B without delta-agent	07/12/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/12/26
E43.	Unspecified severe protein-calorie malnutrition	07/12/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	07/12/26
E78.5	Hyperlipidemia unspecified	07/12/26
F17.200	Nicotine dependence unspecified uncomplicated	07/12/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	07/12/26
R13.12	Dysphagia oropharyngeal phase	07/12/26
I95.9	Hypotension unspecified	07/12/26
E66.9	Obesity unspecified	07/12/26
Z68.30	Body mass index [BMI] 30.0-30.9 adult	07/12/26

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

Amoxicillin And Clavulanate Potassium - Amoxicillin: Clavulanate Potassium 500-125 MG / 1 Tablet by mouth 2 times daily for 5 days
Sodium Bicarbonate - Sodium Bicarbonate 650 MG / 1 Tablet by mouth 3 times daily
AMLODIPINE 5 MG / 1 Tablet by mouth daily Do not start before July 9, 2026.
Metoprolol Succinate - Metoprolol Succinate Extended Release 24 HR 100 MG / 1 Tablet by mouth daily Do not start before July 9, 2026.
MULTIVITAMIN Take 1 tablet by mouth daily
ONDANSETRON Disintegrating 4 MG / 1 Tablet by mouth every 8 hours as needed for Nausea
PANTOPRAZOLE Delayed Release 40 MG tablet by mouth daily
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 MG capsule by mouth every evening
THIAMINE 100 MG / 1 Tablet by mouth daily
NICOTINE 14 MG/24HR patch / Place 1 patch skin every morning for 7 days

14. DME and Supplies:

None of the above

15. Safety Measures:

standard precautions, fall precautions, cardiac precautions, ambulates with assistance

16. Nutrition:

soft

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, WEAKNESS

18.B. Activities Permitted

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: 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

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

Homebound status: Due to diagnosis of Alcoholic liver disease unspecified, 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 47-year-old male with a significant past medical history of alcohol use disorder, chronic hepatitis B, hypertension, chronic kidney disease (CKD), gastroesophageal reflux disease (GERD), congestive heart failure (CHF), severe protein-calorie malnutrition, dysphagia, obesity, and chronic anemia. He was recently hospitalized for a gastrointestinal (GI) bleed resulting in severe anemia and pancytopenia associated with alcoholic liver disease, during which he required a blood transfusion. The hospitalization was further complicated by acute kidney injury (AKI) superimposed on CKD and hepatic encephalopathy. Upon the skilled nursing admission visit, the patient was seated in the living room with his wife present. He was alert and oriented to person, place, and time, cooperative, and denied pain or discomfort. He reported experiencing significant generalized weakness during hospitalization with an inability to ambulate; however, he has since regained most of his strength and is now ambulating independently without the use of an assistive device, although mild generalized weakness remains evident. Medication reconciliation was completed, with all prescribed medications available in the home and no missing medications or refill needs identified. The patient reported a scheduled follow-up appointment with his primary care provider the following day to review recently initiated and adjusted medications. Admission paperwork was completed and signed, and the patient verbalized understanding of and agreement with the plan of care. A comprehensive physical therapy evaluation demonstrated that the patient is independent with functional mobility and resides with his wife and two sons in a townhouse with five steps to enter and the bedroom and bathroom located on the second floor. He independently performs bed, chair, and toilet transfers, ambulates approximately 200 feet on indoor surfaces without an assistive device, negotiates 14 stairs using a handrail independently, ambulates approximately 100 feet on uneven outdoor cement surfaces independently, and reports independent car transfers. Balance and mobility assessments revealed a Tinetti Balance and Gait Score of 25/28 and a Timed Up and Go (TUG) time of 13 seconds, indicating good functional mobility and safe community ambulation. The patient was determined to be safe within his home and community environments. He declined additional skilled physical therapy services and did not feel a written home exercise program was necessary, stating he was familiar with therapeutic exercises from previously assisting his mother during her rehabilitation following joint replacement surgery. Physical therapy services were concluded with discharge to self-care. A skilled occupational therapy evaluation was also completed following hospitalization. Prior to hospitalization, the patient was independent with all basic activities of daily living (ADLs), functional transfers, and household ambulation. At the time of evaluation, he demonstrated independence with basic self-care tasks, functional transfers, and functional ambulation without the need for an assistive device, with no deficits requiring skilled occupational

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/12/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Qinglin Gao
2391 Greenspring Dr
Timonium, MD 21093
PHONE: 18007777904 FAX: NPI: 1053381780

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 : 07/08/2026

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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therapy intervention. Consequently, no additional OT services were recommended, and the evaluation was completed as an evaluation-only visit. Skilled nursing services are medically necessary and will continue at a frequency of one visit per week for six weeks to provide ongoing medication management, comprehensive assessment, and disease process education related to hepatic encephalopathy, AKI on CKD, chronic anemia, alcoholic liver disease, and fall prevention. Education was provided regarding medication adherence, recognition and reporting of worsening symptoms, safety precautions, and the importance of attending scheduled follow-up appointments and complying with the prescribed treatment plan. The patient and caregiver demonstrated understanding of the education provided and agreed to continue with the established plan of care while being monitored for changes in clinical status, treatment compliance, and potential complications requiring further intervention.
 Date of Order 07/12/2026 Orders Physician Face-to-Face Date: 07/08/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Alcoholic liver disease unspecified 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 Gao, Qinglin

SN Careplans

SN WK1: 1 (07/12/26-07/18/26) ,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)

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

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:Refused

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1400 - Dyspnea, limited strength, obesity (NU)

PROCEDURES: cough/deep breathing exercises, incentive spirometer

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

SN Goals

PATIENT-STATED GOAL: To sort out my medications with my Doctor and regain my 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

PT Careplans

PT WK1: 1 (07/12/26-07/18/26)

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

PROCEDURES: home exercise program: Client declined due to he is familiar with exercise

PT Goals

PATIENT-STATED GOAL: States he feels he is back to his baseline

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/12/2026

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and he will do them on his own, 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 - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK1: 1 (07/12/26-07/18/26)

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

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Evaluation only

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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 - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 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	07/12/2026