Home Health Certification and Plan of Care

Order ID: 1150/20592

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
15148806	05/18/2026	From: 07/17/2026 To: 09/14/2026	25760	217058

6. Patient's Name and Address

Chan Lam
3157 LORENZO LN,
WOODBINE, MD 21797-
443-878-8938

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 05/18/1944 | **9.Sex** Male

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

LIPITOR 40 mg / 1 Tablet by mouth daily for cholesterol
COZAAR 50 mg / 1 Tablet by mouth daily
Zyloprim - Allopurinol 300 mg / 1 Tablet by mouth once a day
Colchicine - Colchicine 0.6 mg by mouth once a day For Gout

11. ICD	Principal Diagnosis	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	05/18/26

13. ICD	Other Pertinent Diagnoses	Date
N18.32	Chronic kidney disease stage 3b	05/18/26
S00.03XD	Contusion of scalp subsequent encounter	05/18/26
S00.01XD	Abrasion of scalp subsequent encounter	05/18/26
R41.3	Other amnesia	05/18/26
M10.9	Gout unspecified	05/18/26
E78.00	Pure hypercholesterolemia unspecified	05/18/26
M17.0	Bilateral primary osteoarthritis of knee	05/18/26
H90.5	Unspecified sensorineural hearing loss	05/18/26
Z91.81	History of falling	05/18/26
Z86.0100	Personal history of colonic polyps	05/18/26

14. DME and Supplies:
rolling walker, grab bars, bath bench, commode, 4 wheeled walker

15. Safety Measures:
standard precautions, fall precautions, ambulates with device, activity supervision

16. Nutrition:
regular

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
No Restrictions

19. Mental & Pyschosocial Status: COGNITION: 2. Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance)., ANXIETY: , SOCIAL ISOLATION: 1 Requires assistance, BEHAVIORAL ISSUES: 2 independent, HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: N/A, MOBILITY: N/A

22.B.Discharge Plans
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, 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 with a recent history of falls resulting in injury, including a scalp laceration with bleeding following a recent fall. Skilled nursing visit was completed with the patient's son, Kyle Lam, present and assisting with translation due to the patient speaking a specialized Chinese dialect. The patient demonstrated intermittent ability to answer questions appropriately during the visit; however, he frequently struggled with word finding and communication. Per family report, the patient has a history of transient ischemic attacks (mini strokes) and mild cognitive impairment, contributing to fluctuating cognition and difficulty expressing himself verbally. Family reports the patient has "good and bad days" cognitively, and during assessment he was inconsistent in orientation, including inability to reliably state the current year. The patient is unable to recall the circumstances surrounding his recent fall, and the family remains uncertain regarding the cause. Past medical history is significant for hypertension, chronic kidney disease stage 3B, gout, bilateral knee osteoarthritis, hypercholesterolemia, mild cognitive impairment, hearing loss, and history of TIA/stroke. The patient also reports blurred vision in the right eye. Medication management and safety concerns were addressed extensively during the visit. The patient's daughter, Mon, currently fills the patient's pill organizer weekly, while the patient has historically self-administered medications independently. During assessment, the patient correctly identified that he had taken his medications for the current day; however, family confirmed he missed medications the previous day and the patient was unable to correctly identify the medication slot for the following day. Due to observed cognitive deficits and medication noncompliance risk, RN strongly recommended that family members assume full responsibility for medication administration and supervision moving forward. Kyle and Mon verbalized understanding and agreed to manage medications directly. The patient resides with three of his children and grandchildren in a multi-story home but is now confined to the first floor due to mobility limitations and fall risk. Family reports strong support and supervision within the home, stating that someone is consistently present to monitor the patient. Newly installed home cameras allow the family to observe the patient's daily routine, which reportedly includes bathing, dressing, brushing teeth, and eating breakfast with supervision or modified independence. During the visit, the RN observed the patient ambulating to the bathroom using a rollator walker, which he parked outside the bathroom before transitioning to a cane inside the bathroom due to limited space. The patient demonstrated impaired gait mechanics, including shuffling gait pattern, reduced stride length, slowed mobility, postural instability, and decreased balance, requiring increased time and effort for transfers and ambulation. RN expressed significant concern regarding bathroom safety and advised family that the patient should not ambulate to or use the bathroom independently due to high fall risk and need for total assistance during toileting tasks. Recommendations included installation of grab bars, use of non-skid shower mats, maintaining clutter-free walkways, and reinforcement of an emergency/fire safety plan. Family verbalized understanding and stated they are actively decluttering the home environment. Family also reported the patient previously used the upstairs level of the home but has not used stairs for the past 3-4 years. Patient has experienced four falls within the past year and has demonstrated progressive physical decline over several months, including worsening weakness, impaired endurance, balance deficits, and increased reliance on assistive devices. The patient has used a cane for approximately 3-4 years, a rollator walker for approximately 2 years, and a wheelchair for longer-distance mobility. Current durable medical equipment includes a rollator walker, cane, rolling walker, bedside commode, bed rail, and wheelchair. Patient demonstrates generalized deconditioning, impaired transfer safety, and increased fall risk. Skilled physical therapy evaluation identified deficits in gait, balance, endurance, strength, and mobility requiring skilled intervention. Skilled PT services were initiated for gait training, transfer training, strengthening exercises, balance training, fall prevention, and patient/caregiver education with goals of improving functional mobility, maximizing safety, reducing fall risk, and preventing hospitalization. Additionally, occupational therapy assessment noted the patient remains independent in basic ADLs with supervision to moderate assistance as needed. The patient continues to demonstrate difficulty with communication and cognitive processing due to prior TIA/stroke history. Home exercise program was initiated, including deep breathing exercises and hand strengthening exercises to improve endurance, strength, and functional performance. Skilled OT intervention remains medically necessary to improve strength, activity tolerance, safety awareness, fall prevention, maintenance of independence, and overall quality of life. Family also reported that home health aide services through HomeCentris are being initiated to further support the patient's daily care needs and supervision within the home environment.
 Date of Order 07/16/2026 Orders Physician Face-to-Face Date: 03/09/2026 Clinical Condition Requiring Home Care per

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/16/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Felecia Waddleton Willis
7070 Samuel Morse Dr
Columbia, MD 21046
PHONE: FAX: NPI: 1366673097

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 : 03/09/2026

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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Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat, hha-adl's due to Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 4 - Recertification Notes: The patient is recertified due to OA of both knees, mild cognitive impairment, and difficulty with gait requiring assistance for ADLs and IADLs. The patient demonstrates weakness of the upper extremity, difficulty with balance, limited knee flexion that affects mobility, requires assistance using his rollator for functional ambulation, is contact guard assistance for transfers, and remains a high fall risk with a recent fall a couple of weeks ago. Continued skilled occupational therapy services remain medically necessary to address ADLs, transfers, and functional ambulation while reducing fall risk and maximizing functional independence.
 Physician Waddleton Willis, Felecia

SN Careplans

SN Goals

OT Careplans

OT WK1: 6 (07/17/2026 - 07/18/2026), WK2: 1 (07/19/2026 - 07/25/2026), WK3: 1 (07/26/2026 - 08/01/2026), WK4: 1 (08/02/2026 - 08/06/2026)

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:

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 4. Multiple emergency department visits (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 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: abn cholesterol > 200 mg/dL, M1033 - Exhaustion, poor muscle tone, muscle weakness, limited strength, weak hand grips,

OT Goals

PATIENT-STATED GOAL: increase strength R UE

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

Shower/Bathe Self - 06. Independent

Don/Doff Footwear - 06. Independent

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

Patient will demonstrates improved bilateral upper extremity muscle strength from 3+/5 mmt to 4/5 mmt to improve Adls and transfers safely

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Lower Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/16/2026

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balance deficit

PROCEDURES: Therapeutic exercise: Using 1 lb dumbbells of bilateral upper extremity, Functional ambulation : Using rolling walker/rollator safely, Medication review: Patient/caregiver recalls related purpose and schedule of medications, transfers training: Transfer 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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, 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, Patient will demonstrates improved bilateral upper extremity muscle strength from 3+/5 mmt to 4/5 mmt to improve Adls and transfers safely

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/16/2026