Home Health Certification and Plan of Care

Order ID: 1150/20717

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
84168957	07/21/2026	From: 07/21/2026 To: 09/18/2026	28191	217058

6. Patient's Name and Address
Anthony Barbieri
9215 Gardenia Rd,
Perry Hall, MD 21236-
443-903-1140

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 09/19/1964 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I35.0	Nonrheumatic aortic (valve) stenosis	07/21/26

13. ICD	Other Pertinent Diagnoses	Date
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	07/21/26
I10.	Essential (primary) hypertension	07/21/26
E78.5	Hyperlipidemia unspecified	07/21/26
Z98.61	Coronary angioplasty status	07/21/26
Z87.891	Personal history of nicotine dependence	07/21/26

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

LIPITOR eq 20 mg base 20 MG / 1 Tablet by mouth daily For cholesterol and heart protection
Furosemide - Furosemide 40 mg 40mg; 1 tab by mouth once a day fluid pill
COZAAR 50 MG / 1/2 tab by mouth daily blood pressure
Warfarin - Warfarin Sodium 5mg; 1 tab by mouth once a day blood thinner/AVR
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg; 1 tab by mouth every 4 hours as needed for pain
NORVASC eq 10 mg base 10 MG / 1 Tablet by mouth daily blood pressure
Asa 81 Mg - Aspirin 81mg; 1 tab by mouth once a day prophylactic
Tylenol Es - Acetaminophen 500mg; 1 tab by mouth as necessary for pain
DRISDOL 1,250 mcg (50,000 unit) / 1 Capsule by mouth every 7 days tuesday
Carvedilol - Carvedilol 3.125 mg 3.125mg; 1 tab by mouth twice a day blood pressure/heart

14. DME and Supplies:
bath bench, incentive spirometer

15. Safety Measures:
standard precautions, fall precautions, bleeding precautions, medication safety, cardiac precautions, anticoagulant precautions, activity supervision

16. Nutrition:
cardiac diet

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Up As Tolerated, Exercises Prescribed

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
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Nonrheumatic aortic (valve) stenosis, 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 status post mechanical aortic valve replacement (AVR) with a past medical history significant for hypertension, hyperlipidemia, aortic stenosis, and a history of smoking. The patient was recently seen at Kaiser for laboratory monitoring and remains on warfarin 5 mg daily with a therapeutic INR goal of 2.0-3.0. The most recent INR was 2.2, which is within the prescribed therapeutic range. Skilled nursing services have been ordered at a frequency of 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> per week for 4 weeks, then 1 visit per week for 2 weeks, with physical and occupational therapy evaluations also ordered. The patient resides in a multilevel home, and family members assist with activities of daily living and instrumental activities of daily living as needed. During the skilled nursing assessment, the patient was alert and oriented to person, place, and time and was in no acute distress. The patient reported 0/10 pain at rest with mild discomfort during movement. The patient denied shortness of breath. Lung sounds were diminished throughout all lung fields, but no acute respiratory distress was observed. The patient reported a good appetite, and the last bowel movement occurred on the day of the visit. The patient is currently ambulating independently without the use of an assistive device. Medication reconciliation and review were completed. Skilled nursing reviewed all prescribed medications, including dosage, frequency, indications, and pertinent side effects, with particular emphasis on safe warfarin therapy. The patient and family received education regarding signs and symptoms of bleeding, the importance of maintaining the prescribed INR range, medication adherence, sternal precautions following mechanical AVR, and proper care of the closed sternal incision. The incision remained closed without reported complications. Both the patient and family were receptive to the education provided and verbalized understanding of all instructions. A skilled occupational therapy evaluation was completed following hospitalization for mechanical aortic valve replacement. Prior to hospitalization, the patient was independent with basic self-care, functional transfers, and household ambulation while residing in a multilevel home requiring negotiation of 6 steps to enter the home and 13 stairs to access the bedroom. At the time of evaluation, the patient demonstrated independence with basic self-care, functional transfers, and functional ambulation without the use of an assistive device, indicating a return to baseline functional performance. No skilled occupational therapy needs were identified, and no additional occupational therapy services are warranted at this time. However, the patient would benefit from skilled physical therapy to address stair negotiation, improve endurance, and maximize safety with mobility within the home environment. The plan is to continue skilled nursing for ongoing anticoagulation monitoring, medication management, postoperative assessment, reinforcement of <hility is-highlighty="true" role="mark" data-hility="93032137-0230-4c13-a00b-e29ab027a8f4" data-hility-name="bleeding precautions" data-hility-match="highlight-pass-43:1" data-decoration-type="background" style="--decoration-thickness: auto;">bleeding precautions</hility> and sternal precautions, cardiovascular monitoring, incision surveillance, patient and caregiver education, and coordination of care with the healthcare team.
 Date of Order 07/21/2026 Orders Physician Face-to-Face Date: 07/15/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Nonrheumatic aortic (valve) stenosis 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 OT Eval Notes:
 Physician Desai, Apurva

SN Careplans | SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/21/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Apurva Desai
3400 Box Hill Corp Ctr Dr St 100-200
Abingdon, MD 21009
PHONE: 4436431500 FAX: 14436431505 NPI: 1346396348

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 : 07/15/2026

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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SN WK1: 1 (07/21/26-07/25/26) ,WK2: 2 (07/26/26-08/01/26) ,WK3: 2 (08/02/26-08/08/26) ,WK4: 2 (08/09/26-08/15/26) ,WK5: 1 (08/16/26-08/22/26) ,WK6: 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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 8. Currently reports exhaustion

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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, lung sounds not clear, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, limited endurance, #1 - Other - Other - midline sternum - midline sternum open to air

PROCEDURES: physician-ordered wound care: #1 - Other - Other - midline sternum - midline sternumopen to air: KEEP MIDLINE STERNAL INCISION OPEN TO AIR, 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, * how to achieve wound healing including 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

PATIENT-STATED GOAL: TO STAY HEALTHY

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 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

OT Careplans

OT WK2: 1 (07/26/26-08/01/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0170O1 - 12 Steps, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

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

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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/21/2026

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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

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
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