Home Health Certification and Plan of Care

Order ID: 1150/20734

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
67244268	05/26/2026	From: 07/25/2026 To: 09/22/2026	17681	217058

6. Patient's Name and Address

Warren Everett
4218 Oakford Ave,
BALTIMORE, MD 21215-
443-759-6438

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 08/24/1953 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
L89.153	Pressure ulcer of sacral region stage 3	05/26/26

13. ICD	Other Pertinent Diagnoses	Date
L89.616	Pressure-induced deep tissue damage of right heel	05/26/26
L89.891	Pressure ulcer of other site stage 1	05/26/26
T83.511A	I/I react d/t indwelling urethral catheter init	05/26/26
N13.6	Pyonephrosis	05/26/26
B95.2	Enterococcus as the cause of diseases classified elsewhere	05/26/26
G20.A1	Parkinson's dis w/o dyskinesia w/o mention of fluctuations	05/26/26
I35.0	Nonrheumatic aortic (valve) stenosis	05/26/26
I10.	Essential (primary) hypertension	05/26/26
J44.89	Other specified chronic obstructive pulmonary disease	05/26/26
E78.5	Hyperlipidemia unspecified	05/26/26
D64.9	Anemia unspecified	05/26/26
D69.6	Thrombocytopenia unspecified	05/26/26
G31.84	Mild cognitive impairment of uncertain or unknown etiology	05/26/26
N40.1	Benign prostatic hyperplasia with lower urinary tract symp	05/26/26
R33.8	Other retention of urine	05/26/26
E04.9	Nontoxic goiter unspecified	05/26/26
E87.6	Hypokalemia	05/26/26
E43.	Unspecified severe protein-calorie malnutrition	05/26/26
Z79.01	Long term (current) use of anticoagulants	05/26/26
Z87.891	Personal history of nicotine dependence	05/26/26
Z86.711	Personal history of pulmonary embolism	05/26/26
Z86.718	Personal history of other venous thrombosis and embolism	05/26/26
Z74.01	Bed confinement status	05/26/26

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

Crestor - Rosuvastatin Calcium take 5 mg tablet by mouth once a day 5 mg, 1 time daily at bedtime
Flomax - Tamsulosin Hydrochloride take 0.4 mg capsules by mouth once a day 0.4 mg, 1 time daily every evening for Urinary retention
Tylenol - Acetaminophen take 650 mg Tablet by mouth every 6 hours 650 mg, Oral, every 6 hours PRN for fever and pain
Coumadin - Warfarin Sodium 5 mg take 5 mg tablet by mouth once a day 10 mg, 1 time daily for a fib
Potassium - Potassium Chloride 20meq by mouth twice a day Supplement. Blood drawbetween 6/7-13/26
Amilodipine - Amlodipine Besylate 5mg by mouth in the morning HTN
Lactobacillus - Lactinex GG by mouth once a day GI health
Coumadin - Warfarin Sodium 5 mg 5mg by mouth once a day For blood coagulation
Advair - Fluticasone Propionate: Salmeterol Xinafoate 100-50 MCG/ACT , take 1 puff inhaler inhalant twice a day 1 puff, 2 times daily
Pulmicort - Budesonide Take 0.5 mg/2ml inhalant twice a day 0.5 mg/2ml, 2 times daily
Albuterol Nebulizer - Albuterol 2.5mg/3ml inhalant once a day As needed for wheezing
Mupirocin - Mupirocin 2% topical once a day Once daily for wound care
Alginate - topical two times per week 2-3 times a week for wound care to right ankle
Bacitracin Zinc And Polymyxin B Sulfate - Bacitracin Zinc: Polymyxin B Sulfate Ointment topical as necessary
Santyl - Collagenase 250u/gr topical once a day Apply 1 application to skin daily
Doctor's comments number of wounds sacral size of each wound width cm length cm

14. DME and Supplies:

wound care supplies, urinary/catheter supplies, hospital bed

15. Safety Measures:

fall precautions, transfer with assist, supervision at all times, standard precautions, bleeding precautions, anticoagulant precautions, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

soft, fluids for hydration, , low sodium, low cholesterol, cardiac diet

17. Allergies:

no known allergies

18.A. Functional Limitations

Bowel/Bladder Incontinence, Ambulation, Paralysis, Endurance

18.B. Activities Permitted

Complete Bedrest

19. Mental & Pyschosocial Status: COGNITION: 2. Accurate within 5 days, ANXIETY: , SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Pressure ulcer of sacral region stage 3, 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:

Start of Care (SOC) assessment completed with all required consents signed by the patient's wife/caregiver. The patient is a 72-year-old male with a significant medical history including Parkinson's disease, hypertension, recurrent pulmonary embolism/deep vein thrombosis (PE/DVT), asthma, left femur shaft fracture, and recent hospitalization for kidney stones involving both the kidneys and bladder. Due to advanced Parkinson's disease, severe functional decline, and current medical condition, the patient is bedridden and homebound, requiring an adjustable bed, continuous supervision from one caregiver, and maximum assistance with all mobility and activities of daily living. Leaving the home requires considerable effort and presents significant safety concerns. The patient recently experienced an extended hospitalization related to kidney stones and potassium replacement therapy, which reportedly contributed to increased diarrhea. A follow-up telephone appointment was scheduled for 05/28/2026. At the caregiver's request, the nurse contacted case manager Belinda Houston regarding laboratory orders. A potassium level order was received and subsequently completed. Laboratory specimens were obtained during the visit and transported to the KP South Baltimore location for processing without incident. The patient completed a three-day potassium supplementation regimen the day prior to the visit. The caregiver was instructed that she would be contacted regarding laboratory results and any additional recommendations. Per caregiver report, the patient is expected to undergo multiple future surgical procedures for kidney stone removal; however, she expressed concern regarding the patient's underlying cardiac condition and ability to tolerate surgery. The patient is expected to receive a cardiac monitor by mail, which he will wear for two weeks before returning it for

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Nkechinyerem Eseonu Ewoh
7070 Samuel Morse Dr
Columbia, MD 21246
PHONE: FAX: NPI: 1114247541

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 : 05/22/2026

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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evaluation. The caregiver also reported that a pacemaker may be needed in the future. Current medications include Amoxicillin 500 mg three times daily for 10 days, Hydralazine 100 mg three times daily, and Miralax as needed. INR was reported by the caregiver as 1.6. No abnormal bleeding was reported. Assessment revealed an indwelling Foley catheter that was last changed on 05/24/2026 at St. Joseph Hospital and remained patent and intact during the visit. The patient had a bowel movement during the visit described as loose/wet but not watery. No wound care orders were available at the time of assessment despite requests from the caregiver and case manager. The caregiver reported application of zinc paste to the buttocks and topical treatment to the right ear. No drainage or signs of infection were observed. Photographs were obtained for documentation purposes. Physical Therapy evaluation was completed and revealed significant functional decline following recent hospitalization. The patient remains bedbound with markedly impaired bilateral lower extremity mobility and severe knee contractures, allowing only approximately 15 degrees of available flexion range of motion. At discharge from previous home health physical therapy services, the patient had been compliant with a daily bilateral lower extremity home exercise program (HEP). Physical therapy had previously recommended use of a bolster beneath the knees to facilitate gradual stretching; however, the caregiver reported inconsistent use. The patient would benefit from ongoing skilled physical therapy as part of a maintenance program to promote compliance with the HEP, minimize progression of contractures, preserve available range of motion, and reduce risk for skin breakdown and further functional decline. Occupational Therapy evaluation was also completed. The patient remains bedbound and is dependent on caregivers for the majority of activities of daily living. He is able to participate in self-feeding with minimal to moderate assistance; however, the caregiver reports a gradual decline in this ability over recent months. The patient demonstrates impaired upper extremity function secondary to significant shoulder and hand contractures. Although left-hand dominant, he has increasingly relied on the right hand because left-sided contractures are more severe. Despite these limitations, the patient retains a functional left-hand grip. Skilled occupational therapy services are recommended every other week to address ADL retraining, therapeutic exercise, maintenance of upper extremity function, positioning strategies, and caregiver education to maximize safety and functional independence while reducing the risk of further contracture development. The patient and caregiver were educated regarding disease management, medication compliance, Foley catheter care, monitoring for signs and symptoms of infection, <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>, pressure injury prevention, contracture management, and the importance of adhering to prescribed therapy programs. The plan of care includes ongoing skilled nursing for assessment and monitoring of the patient's complex medical conditions, laboratory follow-up, medication management, catheter assessment, coordination with the physician and case manager, and continued physical and occupational therapy services to maintain function, prevent complications, and support the caregiver in providing safe and effective care within the home setting.
 Date of Order 07/20/2026 Orders Physician Face-to-Face Date: 05/22/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat, hha-adl's due to Pressure ulcer of sacral region stage 3 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 sacral buttocks stage 3 pressure wound requiring Santyl daily, wound care with heel protectors to both heels, right ear and left buttock wounds open to air, and ongoing wound assessment and measurement. The patient also requires maintenance and Foley catheter changes, with Foley catheter intact and draining light amber colored urine, routine potassium levels ordered following hospitalization for low potassium, and continued skilled nursing management after hospitalization for suspected infection with no culture growth. Additionally, the patient is bedbound, dependent for bathing, dressing, and transfers, with limited ROM of bilateral upper extremities, limited grip strength, and requiring OT services to decrease decline in function for self-feeding tasks.
 Physician Eseonu Ewoh, Nkechinyerem

SN Careplans

SN WK2: 1 (07/26/26-08/01/26) ,WK3: 1 (08/02/26-08/08/26) ,WK5: 1 (08/16/26-08/22/26) ,WK7: 1 (08/30/26-09/05/26) ,WK9: 1 (09/13/26-09/19/26)

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

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; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds ; 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.

SN Goals

PATIENT-STATED GOAL: Caregiver wants patient to get better

GOALS
patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

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

meal preparation is available to patient for all meals

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/20/2026

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Sacral buttocks wound apply 1 application santayl daily. Right ear and left buttocks wound open to air; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydrationMonitor for skin break down
Advance Directive:POA wife

PROBLEMS IDENTIFIED ON ASSESSMENT: M1620 - Bowel Incontinence, dark-colored urine, poor muscle tone, loss of appetite, constipation, open sores/lesions, #1 - - Posterior Right Buttock -

PROCEDURES: physician-ordered wound care: #1 - - Posterior Right Buttock -: Sacral buttocks wound apply 1 application santayl daily. Right ear and left buttocks wound open to air, cough/deep breathing exercises, apply compression bandage, physician-ordered wound care: Sacral buttocks wound apply 1 application santayl daily. Right ear and left buttocks wound open to air, wound vacuum, monitor intake & output, catheter change, care & irrigation, coordinate/arrange preparation of missing meals, coordinate/arrange removal of insects/rodents present in the patient's living environment, coordinate/arrange patient access to necessary medical care considering patient inability to pay, coordinate/arrange transportation services, venipuncture: Potassium levelsc, monitor dialysis schedule

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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient has access to necessary medical care considering inability to pay, meal preparation is available to patient for all meals

patient/caregiver recalls
* urinary catheter management including how to flush catheter
* change and wash drainage bags
* prevent infection including proper handwashing
* positioning of catheter
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

patient has access to necessary medical care considering inability to pay

OT Careplans

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

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, GG0170S1 - Wheel 150 feet, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170C1 - Lying to sitting/bed, GG0170B1 - Sit to Lying, GG0170A1 - Roll left & Right

PROCEDURES: cough/deep breathing exercises, therapeutic exercises: Passive range of motion, assist with feeding/eating: with built up utensils

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, Roll left & Right - 01. Dependent, Sit to Lying - 01. Dependent, Lying to sitting/bed - 01. Dependent, Sit to Stand - 01. Dependent, Chair to Bed to Chair - 01. Dependent, Toilet Transfer - 01. Dependent, Car Transfer - 01. Dependent, Wheel 50 ft w 2 Turns - 01. Dependent, Wheel 150 feet - 01. Dependent, Oral Hygiene - 03. Partial/moderate assistance, Toileting Hygiene - 01. Dependent, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 01. Dependent, Lower Body Dressing - 01. Dependent, Don/Doff Footwear - 01. Dependent, Eating - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: To feed himself

GOALS
Roll left & Right - 01. Dependent

Sit to Lying - 01. Dependent

Lying to sitting/bed - 01. Dependent

Sit to Stand - 01. Dependent

Chair to Bed to Chair - 01. Dependent

Toilet Transfer - 01. Dependent

Car Transfer - 01. Dependent

Wheel 50 ft w 2 Turns - 01. Dependent

Wheel 150 feet - 01. Dependent

Oral Hygiene - 03. Partial/moderate assistance

Toileting Hygiene - 01. Dependent

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 01. Dependent

Lower Body Dressing - 01. Dependent

Don/Doff Footwear - 01. Dependent

Eating - 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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/20/2026