Home Health Certification and Plan of Care

Order ID: 1150/20892

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
49704860400	06/01/2026	From: 07/31/2026 To: 09/28/2026	26390	217058

6. Patient's Name and Address
Mirza Baig
1505 Engleside Ave,
GWYNN OAK, MD 21207-
301-291-8828

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 10/01/1949 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
L89.152	Pressure ulcer of sacral region stage 2	06/01/26

13. ICD	Other Pertinent Diagnoses	Date
L98.8	Oth disrd of the skin and subcutaneous tissue	06/01/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	06/01/26
I50.33	Acute on chronic diastolic (congestive) heart failure	06/01/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/01/26
N18.32	Chronic kidney disease stage 3b	06/01/26
D63.1	Anemia in chronic kidney disease	06/01/26
I48.21	Permanent atrial fibrillation	06/01/26
I27.20	Pulmonary hypertension unspecified	06/01/26
E78.5	Hyperlipidemia unspecified	06/01/26
K21.00	Gastro-esophageal reflux dis with esophagitis without bleed	06/01/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	06/01/26
M10.9	Gout unspecified	06/01/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	06/01/26
Z95.1	Presence of aortocoronary bypass graft	06/01/26
Z79.01	Long term (current) use of anticoagulants	06/01/26
Z79.4	Long term (current) use of insulin	06/01/26
Z74.01	Bed confinement status	06/01/26
Z87.891	Personal history of nicotine dependence	06/01/26
E53.8	Deficiency of other specified B group vitamins	06/01/26

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

Furosemide - Furosemide 40 mg 40 mg / 1 Tablet by mouth in the morning for CHF
Metoprolol Tartrate - Metoprolol Tartrate 50 mg 50 mg / 1 Tablet by mouth twice a day for Hypertension
Jardiance - Empagliflozin 10 mg / 1 Tablet by mouth in the morning for dm
Finasteride - Finasteride 5 mg 5 mg / 1 Tablet by mouth at bedtime for BPH
Crestor - Rosuvastatin Calcium 20 mg 20 mg / 1 Tablet by mouth at bedtime for HLD
Acetaminophen - Acetaminophen 500 mg/tablet / Give 2 tablet by mouth every 8 hours as needed for MILD TO SEVERE PAIN NOT TO EXCEED 3GM ACETAMINOPHEN PER DAY
Pantoprazole - Pantoprazole Sodium 40 mg 1 tablet by mouth twice a day
Eliquis - Apixaban 1 tablet by mouth twice a day 5mg tablet
INSULIN GLARGINE 25 UNITS subcutaneous once a day DM

14. DME and Supplies:
cane, rolling walker, bath bench

15. Safety Measures:
standard precautions, , medication safety, fall precautions, emergency phone # clearly displayed, electrical safety measures, bathroom safety, activity supervision, ambulates with assistance,

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance

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

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: , BEHAVIORAL ISSUES: WNL, HISTORY OF DEPRESSION:

20. Prognosis: good

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

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

Homebound status: Due to diagnosis of Pressure ulcer of sacral region stage 2, 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 76-year-old male recently discharged from a skilled nursing facility following hospitalization from 05/04/2026 to 05/10/2026 for acute symptomatic gastrointestinal bleeding with severe anemia requiring transfusion of four units of packed red blood cells, acute-on-chronic heart failure with preserved ejection fraction (HFpEF) exacerbation, acute kidney injury superimposed on chronic kidney disease stage 3B, and an acute gout flare. His extensive past medical history includes hypertension, hyperlipidemia, gastroesophageal reflux disease, gout, chronic kidney disease stage 3B, coronary artery disease status post coronary artery bypass grafting (CABG), chronic diastolic congestive heart failure with pulmonary hypertension, permanent atrial fibrillation, type 2 diabetes mellitus requiring insulin therapy, benign prostatic hyperplasia status post transurethral resection of the prostate (TURP), esophageal varices, acute posthemorrhagic anemia, muscle weakness, gait impairment, and a history of stage II sacral/buttock pressure ulcer. Following hospitalization, the patient completed a rehabilitation stay at a skilled nursing facility and was referred for home health skilled nursing and physical/occupational therapy services. Skilled nursing is scheduled for 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> per week for 1 week, followed by 1 visit per week for 7 weeks, with PT and OT evaluations ordered. Upon assessment, the patient was alert and oriented to person, place, and time. He denied pain at the time of visit. Lung sounds were diminished throughout all fields, and the patient reported shortness of breath with moderate exertion. Appetite was described as fair, and the patient reported his last bowel movement occurred yesterday. No peripheral edema was observed. The patient ambulates with a rolling walker for safety and stability; however, he occasionally furniture surfs within the home. He resides with family members who assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. Previous stage II pressure areas to the buttocks have fully healed, and education was provided regarding the continued daily use of barrier cream to prevent skin breakdown and maintain skin integrity. Physical therapy evaluation revealed significant functional decline related to recent hospitalization, severe anemia, heart failure exacerbation, chronic kidney disease, and multiple comorbidities. The patient demonstrates generalized weakness, impaired balance, decreased endurance, reduced activity tolerance, dyspnea with exertion, impaired transfers, and abnormal gait, resulting in an increased risk for falls and reduced independence compared to his prior level of function. Bilateral upper extremity strength was assessed at approximately 4/5 manual muscle testing. The patient requires contact guard assistance for sit-to-stand and toilet transfers and benefits from verbal cueing for proper limb placement and safety awareness. He requires increased effort and assistance for functional mobility within the home and demonstrates limited

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/27/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Mateen Awan
10796 Hickory Ridge Rd
Columbia, MD 21044
PHONE: 4109929355 FAX: 14109923447 NPI: 1316918303

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 : 05/25/2026

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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tolerance for ambulation and performance of ADLs. Skilled nursing reviewed all prescribed medications, including indications, dosages, administration schedules, and potential side effects. The patient reported not checking his blood glucose level on the day of the visit despite having diabetic monitoring supplies available in the home. The last recorded weight was obtained during hospitalization. Education was provided regarding chronic disease management, medication adherence, blood glucose monitoring, heart failure self-management, fall prevention, skin integrity maintenance, and recognition of symptoms requiring prompt medical attention. The patient would benefit from continued skilled nursing services for ongoing assessment, disease process education, medication management, monitoring of cardiopulmonary and diabetic status, and reinforcement of compliance with the prescribed treatment regimen. Continued physical and occupational therapy services are indicated to address strength deficits, balance impairments, transfer safety, gait training, endurance limitations, and functional independence with ADLs and mobility in order to reduce fall risk and prevent rehospitalization.
 Date of Order 07/27/2026 Orders Physician Face-to-Face Date: 05/25/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Pressure ulcer of sacral region stage 2 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 continued need for skilled PT services to further increase strength, improve balance, and increase safety and independence in functional mobility in order to return to PLOF. Continued skilled OT services remain medically necessary to address ADLs, transfers, muscle weakness, bathing, and lower body dressing deficits.
 Physician Awan, Mateen

SN Careplans

SN Goals

PT Careplans

PT WK3: 1 (08/09/26-08/15/26) ,WK5: 1 (08/23/26-08/29/26) ,WK7: 1 (09/06/26-09/12/26) ,WK9: 1 (09/20/26-09/26/26)

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: WNL

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 7. Currently taking 5 or more medications, 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/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

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

1 - Step (curb) - 05. Setup or clean-up assistance

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/27/2026

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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:MOLST: 1a) ATTEMPT CPR

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, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair, M1033 - Exhaustion, limited endurance, limited strength, balance deficit

PROCEDURES: cough/deep breathing exercises, glucose testing via monitor, 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. Upgrade as tolerated, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, 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 - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

OT Careplans

OT WK2: 1 (08/02/26-08/08/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, 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, incentive spirometer, equipment 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, * 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, 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: Patient was to get better and be independent

GOALS
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

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

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
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/27/2026