

Home Health Certification and Plan of Care				Order ID: 1150/20947					
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period		4. Medical Record No.		5. Provider No.	
6R97WM4WP59		06/01/2026		From: 07/31/2026 To: 09/28/2026		26221		217058	
6. Patient's Name and Address Ernest Holmboe 7815 Oxford Dr, Elkridge, MD 21075- 443-936-9477					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 03/09/1938 9.Sex Male					10. Medications: Dose/Frequency/Route (N)ew (C)hanged				
11. ICD		Principal Diagnosis			Date		AMIODARONE 200 mg / 1 Tablet by mouth in the morning for Paroxysmal Atrial Fibrillation ENTRESTO 24-26 mg / 1 Tablet by mouth two times a day for CHF Lasix - Furosemide 40 mg 40 mg / 1 Tablet by mouth two times a day for CHF HOLD FOR SBP < 90 Therapeutic M - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 Tablet by mouth in the morning for VITAMIN SUPPLEMENT OMEGA-3 500 mg/capsule / Give 2 capsule by mouth in the morning for Supplement Senokot S - Senna 8.6-50 mg / 1 Tablet by mouth in the morning for Bowel Regimen Synthroid - Levothyroxine Sodium 50 mcg / 1 Tablet by mouth one time a day for Hypothyroidism BEFORE BREAKFAST Coselevelam HCl 625 mg/tablet / Give 2 tablet by mouth twice a day for HYPERLIPIDEMIA Vitamin B + C Complex Tablet (B Complex-C) Give 1 tablet by mouth in the morning for VITAMIN SUPPLEMENT Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 2000 UNIT / 1 Tablet by mouth in the morning for VITAMIN D DEFICIENCY ELIQUIS 2.5 mg / 1 Tablet by mouth every morning and at bedtime for Paroxysmal Atrial Fibrillation Lantus Solostar - Insulin Glargine Recombinant 100 UNIT/ML / Inject 20 unit subcutaneous at bedtime for DM Ozempic (0.25 or 0.5 MG/DOSE) Subcutaneous Solution Pen-injector 2 MG/3ML / Inject 0.25 mg subcutaneous in the morning every Fri for DM2		
11.0		Hypertensive heart disease with heart failure			06/01/26				
13. ICD		Other Pertinent Diagnoses			Date				
150.33		Acute on chronic diastolic (congestive) heart failure			06/01/26				
E11.22		Type 2 diabetes mellitus w diabetic chronic kidney disease			06/01/26				
N18.30		Chronic kidney disease stage 3 unspecified			06/01/26				
L89.620		Pressure ulcer of left heel unstageable			06/01/26				
I25.10		Athscl heart disease of native coronary artery w/o ang pctrs			06/01/26				
J90.		Pleural effusion not elsewhere classified			06/01/26				
N13.30		Unspecified hydronephrosis			06/01/26				
I48.0		Paroxysmal atrial fibrillation			06/01/26				
N13.9		Obstructive and reflux uropathy unspecified			06/01/26				
N20.0		Calculus of kidney			06/01/26				
K57.90		Dvrtclos of intest part unsp w/o perf or abscess w/o bleed			06/01/26				
E78.5		Hyperlipidemia unspecified			06/01/26				
E03.9		Hypothyroidism unspecified			06/01/26				
R33.9		Retention of urine unspecified			06/01/26				
Z79.85		Lng trm (crnt) use injectable non-insulin antidiabetic drugs			06/01/26				
Z79.4		Long term (current) use of insulin			06/01/26				
Z79.01		Long term (current) use of anticoagulants			06/01/26				
Z46.6		Encounter for fitting and adjustment of urinary device			06/01/26				
Z95.0		Presence of cardiac pacemaker			06/01/26				
Z95.5		Presence of coronary angioplasty implant and graft			06/01/26				
Z85.46		Personal history of malignant neoplasm of prostate			06/01/26				
Z87.440		Personal history of urinary (tract) infections			06/01/26				
Z91.81		History of falling			06/01/26				
14. DME and Supplies: wound care supplies, walker, hand held shower, hospital bed, grab bars, 4 wheeled walker, diabetic supplies, bath bench					15. Safety Measures: walker precautions, sharps precautions, medication safety, infectious material management, hand rails, fall precautions, diabetic precautions, bedrails up while in bed, avoid temperature extremes, bathroom safety, ambulates with device, activity supervision, ambulates with assistance				
16. Nutrition: diabetic					17. Allergies: statins				
18.A. Functional Limitations Dyspnea With Minimal Exertion, Endurance					18.B. Activities Permitted Walker, Up As Tolerated				
19. Mental & Pyschosocial Status: COGNITION: 3. Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently, ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:									
20. Prognosis: good									
22. A Rehabilitation Potential: SELF-CARE: , MOBILITY:					22.B.Discharge Plans family/caregiver will be responsible for managing treatment				
Homebound status: Due to diagnosis of Hypertensive heart disease with heart failure, 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 <div>Patient is an 88-year-old male recently discharged home from a rehabilitation facility following an approximately three-month Requiring Homecare:hospitalization and rehabilitation stay related to sepsis. The patient resides at home with his wife and is primarily bedbound, although he is able to ambulate short distances to the bathroom using a walker. The patient's wife serves as his primary caregiver and is supportive in assisting with daily care needs; however, she reports significant personal health challenges, including end-stage cirrhosis of the liver, and stated she has been informed that her prognosis is limited. During the admission visit, the patient's wife requested assistance with completion of all admission paperwork and consent forms. The RN reviewed the documents and repeatedly offered the wife the opportunity to independently read the forms and ask questions regarding the content prior to signing. The wife declined multiple times, stating she did not wish to review the documents and expressed frustration regarding the amount of paperwork required. Following completion of the electronic admission process, the RN overheard the patient's wife expressing concerns to the patient's aide regarding the length of the visit and paperwork process. The RN reapproached the wife and again offered to review all admission documents and answer any questions; however, she declined further review and stated she did not have any concerns regarding the paperwork. Despite caregiver stress and emotional distress related to her own medical condition, no additional questions or requests for clarification were voiced. The patient has additional support from a nearby stepson who assists with caregiving needs as needed. He currently receives daily home health aide services through Always Best Care for approximately four hours per day. Assessment revealed a left heel pressure injury that is reportedly being managed by a nurse practitioner who performs home <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh>; however, the patient and spouse were unable to provide the practitioner's name. Wound care is reportedly scheduled to be performed daily by Personic staff, although the patient and spouse were uncertain regarding the start date of services. Skilled wound care was completed by the RN during today's visit in accordance with physician orders using available supplies. The patient has a significant cardiac history, including prior myocardial infarction requiring pacemaker placement. Vital signs were obtained and remained within acceptable parameters throughout the visit. The patient demonstrated no acute distress,									
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 07/29/2026						25. Date HHA Received Signed POT			
24. Physician's Name and Address Scott Maurer 2465 Route 97 Glenwood, MD 21738 PHONE: 4104899550 FAX: 14104895527 NPI: 1861554974					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 : 05/18/2026				
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. PAGE 1 of 3				

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remained clinically stable, and tolerated all assessment and treatment interventions without complication. Education was provided regarding ongoing wound care, safety, and available support services. At the conclusion of the visit, the patient remained stable with no additional questions or concerns voiced by either the patient or spouse. Patient was also evaluated for skilled home health physical therapy services following hospitalization for acute-on-chronic congestive heart failure exacerbation with preserved ejection fraction, significant fluid overload requiring aggressive diuresis, urinary retention necessitating Foley catheter placement, and generalized debility. Past medical history is significant for coronary artery disease status post percutaneous coronary intervention, congestive heart failure, chronic kidney disease stage III, paroxysmal atrial fibrillation, cardiac pacemaker, type 2 diabetes mellitus with diabetic chronic kidney disease, hypertension, hypothyroidism, history of prostate cancer, recurrent urinary tract complications, history of falls, and chronic mobility limitations. Physical therapy evaluation revealed generalized weakness, impaired balance, decreased endurance, impaired transfer ability, abnormal gait mechanics, and reduced overall functional mobility following recent hospitalization and medical decline. Functional deficits are further impacted by CHF-related activity intolerance, chronic kidney disease, advanced age, Foley catheter management requirements, and multiple chronic comorbidities, resulting in increased fall risk and dependence on assistance for safe mobility and activities of daily living. Skilled physical therapy services are medically necessary to address lower extremity weakness, balance impairments, gait dysfunction, transfer deficits, fall prevention strategies, reduced endurance, and progression of functional mobility to maximize independence, improve safety, and reduce the risk of rehospitalization. Prognosis is considered fair for improvement in functional mobility, safety awareness, and overall function with continued participation in skilled physical therapy services and adherence to the established plan of care.

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</div><div>Date of Order</div><div>">07/29/2026</div><div>">Orders</div><div>">Physician Face-to-Face Date: 05/18/2026</div><div>">Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat, hha-adl's, msw due to Hypertensive heart disease with heart failure</div><div>">Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div>">
</div><div>">4 - Recertification Notes: The patient is recertified due to complicated wound care requiring continued skilled nursing intervention. Continued skilled nursing is medically necessary for wound care management, diabetic monitoring, medication administration, and ongoing patient and caregiver education on deep breathing exercises, clean techniques to prevent infection, and medication administration.</div><div>">
</div><div>">Physician</div><div>">Maurer, Scott</div>

SN Careplans

SN WK2: 1 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26) ,WK6: 1 (08/30/26-09/05/26) ,WK7: 1 (09/06/26-09/12/26) ,WK8: 1 (09/13/26-09/19/26) ,WK9: 1 (09/20/26-09/26/26) ,WK10: 1 (09/27/26-09/28/26)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls- or any fall with an injury- in the past 12 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; 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:ADVANCED DIRECTIVE: MOLST: 1a) ATTEMPT CPR

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, abn cholesterol > 200 mg/dL, dependent edema, abnormal thyroid <> 0.40 - 4.50 mIU/mL, constipation, decreased urine output, limited strength, muscle weakness, limited endurance, extremity burn/tingle/numb, balance deficit, difficulty sleeping, obesity, red/tender pressure points, swell/redness surround. skin, bleeding/discharge at site, bruising/dyscoloration, #2 - Other - Other - Left 3rd and 4th toe - Patients wife cut patients toenails on left foot and cut too far on 3rd and 4th toe causing bleeding and small

SN Goals

PATIENT-STATED GOAL: Not to fall

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 increase caloric intake
- * recalls related medication(s) purpose, schedule

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 is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/29/2026

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wounds	
PROCEDURES: physician-ordered wound care: #2 - Other - Other - Left 3rd and 4th toe - Patients wife cut patients toenails on left foot and cut too far on 3rd and 4th toe causing bleeding and small wounds: monitor for s/s of infection, physician-ordered wound care: #1 - - Posterior Left Heel -: Ultra Mist therapy 2 times weekly by Personic Cleanse with Vashe allow 5 minute soak, Apply calcium alginate, apply ABD pad cover with bordered dressing secure with rolled gauze and tape daily, Caregiver to perform in the absence of the Nurse Additional Orders: apply Santyl to wound bed may use Medihoney until Santyl arrives Compression therapy to the left leg apply proper-size compressive single-layer TubiGrip bandage size E or F, change with dressing changes or as needed for soiling; elevate legs when possible, cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, monitor intake & output 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 increase caloric intake, 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, patient's transportation needs are met, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence	

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/29/2026