Home Health Certification and Plan of Care

Order ID: 1150/21060

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6KA2WU7WT93	08/04/2026	From: 08/04/2026 To: 10/02/2026	28614	217058

6. Patient's Name and Address
Ross Watts
424 Nottingham Road,
Baltimore, MD 21229-
410-409-2380

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 03/30/1949 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
L89.153	Pressure ulcer of sacral region stage 3	08/04/26

13. ICD	Other Pertinent Diagnoses	Date
I48.0	Paroxysmal atrial fibrillation	08/04/26
I10.	Essential (primary) hypertension	08/04/26
E46.	Unspecified protein-calorie malnutrition	08/04/26
L03.115	Cellulitis of right lower limb	08/04/26
I87.2	Venous insufficiency (chronic) (peripheral)	08/04/26
L97.419	Non-prs chr ulcer of right heel and midfoot w unsp severt	08/04/26
L97.519	Non-prs chronic ulcer oth prt right foot w unsp severity	08/04/26
L97.219	Non-pressure chronic ulcer of right calf with unsp severity	08/04/26
L97.928	Non-prs chronic ulc unsp prt of l low leg with oth severity	08/04/26
M84.451D	Pathological fracture right femur subs for fx w routn heal	08/04/26
D64.9	Anemia unspecified	08/04/26
R33.9	Retention of urine unspecified	08/04/26
M16.11	Unilateral primary osteoarthritis right hip	08/04/26
G62.9	Polyneuropathy unspecified	08/04/26
K21.9	Gastro-esophageal reflux disease without esophagitis	08/04/26
M54.2	Cervicalgia (M54.2)	08/04/26
F17.210	Nicotine dependence cigarettes uncomplicated	08/04/26
E87.6	Hypokalemia	08/04/26
Z96.0	Presence of urogenital implants	08/04/26
Z79.01	Long term (current) use of anticoagulants	08/04/26
Z89.212	Acquired absence of left upper limb below elbow	08/04/26

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

Sennosides - Senna 8.6 MG / 1 Tablet by mouth twice a day for bowel regimen Hold for loose stools
GLYCOLAX 17gm/scoopful Give 17 gram by mouth once a day for Bowel regimen Measure 17 grams of powder and dissolve in 4-8oz of preferred drink.
ACETAMINOPHEN Extra Strength Give 500 MG Tablet by mouth every 8 hours for Pain
B Complex-Folic Acid 1 Tablet sublingual once a day for Supplement
Biofreeze - Biofreeze 0 Cool The Pain External Gel 4 % / Apply to neck topical as necessary every shift for Pain

14. DME and Supplies:
urinary/catheter supplies, walker, wound care supplies, cane

15. Safety Measures:
cardiac precautions, smoke detectors , emergency phone # clearly displayed, standard precautions, fall precautions, bleeding precautions, walker precautions, medication safety, transfer with assist, supervision at all times, hip precautions, anticoagulant precautions, activity supervision

16. Nutrition:
high protein, , cardiac diet

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Bowel/Bladder Incontinence, Ambulation, Amputation

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

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: poor

22. A Rehabilitation Potential:
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans
family/caregiver 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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 08/04/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Edna Baffoe-Bonnie
7900 Oak Point Ct
Pasadena, MD 21122
PHONE: 4438701237 FAX: 14432961684 NPI: 1982117388

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 : 07/26/2026

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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Clinical Condition Requiring Homecare:

The patient was discharged home from rehabilitation with a significant medical history including atrial fibrillation, hypertension, chronic urinary retention with an indwelling 16 Fr Foley catheter (5-10 mL balloon) following a failed voiding trial with catheter reinsertion on 7/24/26, protein-calorie malnutrition, anemia, chronic bilateral lower-extremity venous stasis ulcers, stage 3 sacral pressure injury, status post right intertrochanteric hip fracture with a closed right hip incision, left arm amputation, GERD, and neuropathy. The patient resides with a friend, Lynn, who provides assistance as able. The patient would benefit from MSW services for community resources and long-term planning, HHA services for personal care, and PT/OT evaluations; skilled nursing is ordered at a frequency of 1 visit weekly for 12 weeks, with additional visits as indicated. The patient was discharged home with limited wound-care supplies, consisting only of dry dressings. He is alert and oriented 3 and denies pain except during turning and repositioning; he denies shortness of breath. During the visit, the patient was incontinent of a large, soft, brown stool, and the soiled brief was changed with caregiver assistance. The caregiver was educated on using disposable underpads (Chux) rather than diapers to facilitate hygiene and skin care. The Foley catheter was patent and draining clear, yellow urine. Bilateral lower-extremity dressings were intact, and the outer dressings were changed; the underlying venous stasis ulcers were not visualized during the visit. The stage 3 sacral pressure injury is documented in the wound assessment. Per the caregiver, the patient is currently unable to ambulate, although a walker and cane are available in the home. Skilled nursing reviewed the medication list and prescriptions present in the home and instructed the caregiver to have outstanding prescriptions filled. Education was initiated regarding Foley catheter care, skin care, and the importance of frequent repositioning to prevent further skin breakdown. The caregiver was receptive to education but requires continued support and reinforcement.<o:p></o:p>   Date of Order<o:p></o:p> 08/04/2026<o:p></o:p> Physician Face-to-Face Date: 07/26/2026<o:p></o:p> Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Pressure ulcer of sacral region stage 3<o:p></o:p> Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>   1 - SOC - SN Notes:<o:p></o:p> Physician: Baffoe-Bonnie, Edna

SN Careplans

SN WK1: 1 (08/04/26-08/08/26)

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: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 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 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

SN Goals

PATIENT-STATED GOAL: I'M CONCERNED WITH HAVING PERSONAL CARE ND GETTING OUT THE BED

GOALS
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

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

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* 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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/04/2026

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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:The patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments.

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, M1033 - Unintentional Weight Loss, M1620 - Bowel Incontinence, heartburn/indigestion, urine retention, M1610 - Urinary Catheter, muscle spasms, limited strength, limited endurance, limited range of motion, muscle weakness, poor muscle tone, Pain Interference with ADLs, balance deficit, skin breakdown r/t incontinence, #1 - Non-Observable Stasis Ulcer - Other - RIGHT LEGS - OLD BLOODY DRAINAGE NOTED, #2 - Non-Observable Stasis Ulcer - Other - LEFT LEG - OLD BLOODY DRAINAGE NOTED, bleeding/discharge at site, open sores/lesions, #3 - 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles not exposed. - Posterior Sacrum - OLD DRESSING REMOVED WOUND CLEANED WITH WOUND CLEANSER AND COVERED WITH DRY DRESSING

PROCEDURES: physician-ordered wound care: #3 - 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles not exposed. - Posterior Sacrum - OLD DRESSING REMOVED WOUND CLEANED WITH WOUND CLEANSER AND COVERED WITH DRY DRESSING, physician-ordered wound care: #3 - 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles not exposed. - Posterior Sacrum - OLD DRESSING REMOVEDWOUND CLEANED WITH WOUND CLEANSER AND COVERED WITH DRY DRESSING: SN/CG TO CLEANSE THE SACRAL WOUND WITH NSS, PACK WITH SILVER ALGINATE L ZINC TO THE PERIWOUND, COVER WITH BORDERED FOAM DRESSING; EVRY 2-3 DAYS AND AS NEEDED FOR SOILED DRESSING., physician-ordered wound care: #1 - Non-Observable Stasis Ulcer - Other - RIGHT LEGS - OLD BLOODY DRAINAGE NOTED: SN/PG TO CLEANSE WITH NSS, COVER WITH XEROFORM ; ABD PADS, WRAP WITH KERLIX AND SECURE WITH TAPE; DAILY., physician-ordered wound care: #2 - Non-Observable Stasis Ulcer - Other - LEFT LEG - OLD BLOODY DRAINAGE NOTED: SN/PG TO CLEANSE WITH NSS, COVER WITH XEROFORM ; ABD PADS, WRAP WITH KERLIX AND SECURE WITH TAPE; DAILY., cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, monitor intake & output, catheter change, care & irrigation: NO HOME HEALTH ORDERS FOR INDWELLING CATHETER . SN TO TEACH INDWELLING CATHETER CARE ONLY. NO CHANGE ORDERS FOR THE 16FR 5-10 CC CATHETER, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, * 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, * 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, caregiver administers and/or packages medications appropriately

* 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
* 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/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

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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