Home Health Certification and Plan of Care

Order ID: 1150/21072

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
8U85C00VG72	07/31/2026	From: 07/31/2026 To: 09/28/2026	28347	217058

6. Patient's Name and Address

John Hurst
5 Brett Ct Apt 224,
ESSEX, MD 21221-
410-391-6864

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 06/26/1934 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I10.	Essential (primary) hypertension	07/31/26

13. ICD	Other Pertinent Diagnoses	Date
I48.0	Paroxysmal atrial fibrillation	07/31/26
E11.9	Type 2 diabetes mellitus without complications	07/31/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	07/31/26
J44.9	Chronic obstructive pulmonary disease unspecified	07/31/26
E78.5	Hyperlipidemia unspecified	07/31/26
F32.1	Major depressive disorder single episode moderate	07/31/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/31/26
K59.09	Other constipation	07/31/26
E87.1	Hypo-osmolality and hyponatremia	07/31/26
F51.01	Primary insomnia	07/31/26
G89.29	Other chronic pain	07/31/26
M54.9	Dorsalgia unspecified	07/31/26
R26.89	Other abnormalities of gait and mobility	07/31/26
Z79.82	Long term (current) use of aspirin	07/31/26
Z85.118	Personal history of malignant neoplasm of bronchus and lung	07/31/26
Z85.038	Personal history of malignant neoplasm of large intestine	07/31/26
Z95.1	Presence of aortocoronary bypass graft	07/31/26
Z91.81	History of falling	07/31/26

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

MELATONIN 3 mg/tablet / Take 2 tablets (6 mg total) by mouth nightly
SENOKOT 8.6 mg/tablet / Take 2 tablets by mouth 2 (two) times daily
ELAVIL 50 mg/tablet / Take 0.5 tablets (25 mg total) by mouth nightly
TYLENOL 325 mg/tablet / Take 650 mg by mouth 2 (two) times daily
Norvasc - Amlodipine Besylate 5 MG / 1 Tablet by mouth once a day
Vitamin C - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000 MG / 1 Tablet by mouth daily
TOPROL-XL 50 MG / 1 Tablet by mouth daily
CRESTOR 5 MG / 1 Tablet by mouth daily
Vitamin B-12 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox Take 1,000 mcg by mouth once a day
Aspirin Ec - Aspirin 81 MG / 1 Tablet by mouth daily Cardiac prevention method

14. DME and Supplies:

wheelchair, walker, rolling walker, bath bench

15. Safety Measures:

smoke detectors , seizure precautions, emergency phone # clearly displayed, ambulates with assistance, activity supervision, cardiac precautions, hand rails, medication safety, supervision at all times, transfer with assist, bleeding precautions, diabetic precautions, standard precautions, walker precautions, fall precautions, bathroom safety, ambulates with device

16. Nutrition:

low sodium, cardiac diet

17. Allergies:

iodine

18.A. Functional Limitations

Bowel/Bladder Incontinence, Endurance, Dyspnea With Minimal Exertion, Ambulation

18.B. Activities Permitted

Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

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

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Essential (primary) hypertension, 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 92-year-old male referred to home health services following a recent hospitalization and subsequent subacute rehabilitation stay after presenting with fecal leakage and abdominal pain and being diagnosed with bowel impaction. During hospitalization, the patient was also diagnosed with atrial fibrillation and hypertension and was treated and medically stabilized prior to discharge home. Significant past medical history includes lung cancer, colon cancer, coronary artery disease, status post coronary artery bypass grafting, atrial fibrillation, atherosclerotic heart disease, hypertension, hyperlipidemia, chronic obstructive pulmonary disease (COPD), diabetes mellitus, chronic pain, dorsalgia, hyponatremia, gastroesophageal reflux disease, and depression. The patient resides alone in a senior citizens apartment building with elevator access. Prior to the recent hospitalization, the patient was independent in the community, ambulated without an assistive device, independently performed transfers and activities of daily living (ADLs) and instrumental activities of daily living (IADLs), and was able to drive. The patient reports two falls within the past year. On current assessment, the patient is alert and oriented to approximately person, place, and situation (x2-3). Skin is dry and intact. Lung sounds are clear bilaterally, with respirations even and unlabored, and the patient voiced no acute complaints. The patient is considered homebound due to multiple chronic medical conditions, including hypertension, hyperlipidemia, COPD, and a history of falls, which contribute to increased fall risk and reduced safety with community mobility. The patient ambulates with a rollator/assistive device and requires human assistance when leaving the home for safety due to impaired balance and mobility limitations. Physical therapy assessment demonstrates impaired balance, lower-extremity weakness, decreased endurance, and an unsteady gait pattern. Tinetti balance and gait assessment score is 16/28, indicating increased fall risk, and Timed Up and Go (TUG) test is 17.2 seconds, consistent with impaired functional mobility and elevated fall risk. The patient demonstrates mild difficulty with functional transfers and requires a rollator for safe ambulation. During trials of ambulation without an assistive device, increased gait instability was observed, including one loss of balance that the patient was able to self-correct. The patient reports a goal of progressing from the rollator, returning to driving, and regaining his prior level of

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/31/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Dennis Odie
9106 Philadelphia Rd
Baltimore, MD 21237
PHONE: 4107801980 FAX: 14107801984 NPI: 1578593273

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 : 07/04/2026

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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independence. The patient is motivated to participate in therapy and demonstrates good rehabilitation potential. Continued skilled physical therapy is indicated to address balance deficits, lower-extremity weakness, gait instability, transfer ability, endurance, fall prevention, and safe progression of functional mobility. Occupational therapy evaluation further identifies decreased standing balance, reduced standing tolerance, bilateral upper-extremity strength deficits, and decreased overall activity tolerance, resulting in reduced independence with self-care activities, functional transfers, and functional ambulation compared with the patient's prior level of function. Prior to hospitalization, the patient was independent with basic self-care, functional transfers, and ambulation without an assistive device. Skilled occupational therapy is recommended to address these functional deficits through therapeutic exercise, activity tolerance training, balance and functional mobility interventions, ADL retraining, safety and fall-prevention education, and compensatory strategies as appropriate. The plan of care is to continue skilled PT and OT services to improve strength, balance, endurance, functional mobility, and independence with ADLs/IADLs while reducing fall risk and promoting a safe return toward the patient's prior level of function.
 Date of Order 07/31/2026 Orders Physician Face-to-Face Date: 07/04/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Essential (primary) hypertension 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 PT Eval Notes: OT Eval Notes:
 Physician Odie, Dennis

SN Careplans

SN WK1: 1 (07/31/26-08/01/26) ,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)

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), 5. Decline in mental, emotional, or behavioral status in the past 3 months, 7. Currently taking 5 or more medications, 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; 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, D0700 - Social Isolation, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, constipation, M1610 - Urinary Incontinence, limited endurance (MS), limited strength (MS), muscle weakness, B1000 - Vision Deficit, balance deficit (NR), loss of appetite, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, incentive spirometer, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange resources for vision-impaired, coordinate/arrange long-term socialization activities

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

SN Goals

PATIENT-STATED GOAL: To live a normal life without a chair or walker

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

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK2: 2 (08/02/26-08/08/26) ,WK3: 2 (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)

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

PROCEDURES: Medication management : Medication reviewed with pt, home exercise program: Laq, hip flexion, heelraises toe raises sitting 3x10 , perform standing tes with support rollator, or kitchen counter for heelraises, hip flexion, hamstring curls, hip abduction hip extension as tolerated 2-310, equipment training: Assess amb with rollator

PT Goals

PATIENT-STATED GOAL: Pt goal to progress off rollator get back to driving and doing everything on my own

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/31/2026

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as well as without device., work simplification/energy conservation, dynamic standing balance exercises: Work postural trg, righting reaction, improve reaction time, improve hip ankle step strategies by performing standing balance exercises, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

OT Careplans

OT WK1: 1 (07/24/26-07/25/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: Medication Review : Medication reviewed with patient with all medications in the home, home exercise program: Bilateral UE triceps extensions, biceps curls, armchair press-ups, shoulder raises 2-3 sets 8-12 reps, equipment training, work simplification/energy conservation, transfers training: Skilled OT, assist with bathing: Skilled OT, assist with lower body dressing: Skilled OT, assist with upper body dressing: Skilled OT

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, 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

OT Goals

PATIENT-STATED GOAL: Get in the shower

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

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

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
07/31/2026