Home Health Certification and Plan of Care

Order ID: 1150/17935

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
46201805700	04/12/2026	From: 04/12/2026 To: 06/10/2026	22860	217058

6. Patient's Name and Address

Dayontae Claiborne
2 Deveraux Court Apt T4,
GWYNN OAK, MD 21207-
443-883-6094

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 08/08/1990 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
T84.69XA	Infect/inflm reaction due to int fix of site init	04/12/26

13. ICD	Other Pertinent Diagnoses	Date
B95.2	Enterococcus as the cause of diseases classified elsewhere	04/12/26
E10.621	Type 1 diabetes mellitus with foot ulcer	04/12/26
L97.521	Non-prs chronic ulcer oth prt l foot limited to brkdwn skin	04/12/26
L97.511	Non-prs chronic ulcer oth prt r foot limited to brkdwn skin	04/12/26
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	04/12/26
E10.22	Type 1 diabetes mellitus w diabetic chronic kidney disease	04/12/26
N18.6	End stage renal disease	04/12/26
D63.1	Anemia in chronic kidney disease	04/12/26
F41.9	Anxiety disorder unspecified	04/12/26
F32.A	Depression unspecified	04/12/26
E10.40	Type 1 diabetes mellitus with diabetic neuropathy unsp	04/12/26
E03.9	Hypothyroidism unspecified	04/12/26
F17.290	Nicotine dependence other tobacco product uncomplicated	04/12/26
Z98.1	Arthrodesis status	04/12/26
Z99.2	Dependence on renal dialysis	04/12/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	04/12/26
Z79.891	Long term (current) use of opiate analgesic	04/12/26
Z89.419	Acquired absence of unspecified great toe	04/12/26

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

Amoxicillin And Clavulanate Potassium - Amoxicillin: Clavulanate Potassium 500 mg / 125 mg / 1 tablet by mouth once a day for infection for 10 Days
Amoxicillin And Clavulanate Potassium - Amoxicillin: Clavulanate Potassium 500 mg /125 mg / 1 tablet by mouth once a day for infection for 6 weeks
Basaglar - Insulin Glargine KwikPen 100 unit / ml / inject 10 units subcutaneous at bedtime for DM
Calcium Acetate - Calcium Acetate 667 mg / 1 capsule by mouth once a day take with meals, for supplement
CARVEDILOL 6.25 mg / 1 tablet by mouth twice a day for HTN every 12 hours *Hold if Systolic Blood Pressure is less than 110 *Hold if Apical Pulse is less than 60.
Epoetin Alfa Solution 10000 unit / ml / Inject 10000 unit subcutaneous once a day every Tue, Thu, Sat for Anemia give in Dialysis
GABAPENTIN 300 mg / 1 capsule by mouth every 8 hours for neuropathy.
Glucagon Emergency Kit (Glucagon (rDNA)) Inject 1 ml intramuscular as necessary for Blood Sugar less than 60 and unconscious or unresponsive, and call MD.
Insulin Aspart FlexPen Subcutaneous Solution Pen-injector 100 unit / ml subcutaneous before meal Inject as per sliding scale: if 0 - 150 = 0 unit; 151 - 200 = 2 Unit; 201 - 250 = 4 Unit; 251 - 300 = 6 Unit; 301 - 350 = 8 Unit; 351 - 400 = 10 Unit < 80 and >400 call MD/NP, before meals and at bedtime for DM
Levothyroxine Sodium - Levothyroxine Sodium 88 mcg / 1 tablet by mouth in the morning for hypothyroidism
Lisinopril - Lisinopril 5 mg / 1 tablet by mouth once a day for HTN
Midodrine Hydrochloride - Midodrine Hydrochloride 2.5 mg / 1 tablet by mouth once a day every Mon, Wed, Fri for Hypotension
Miralax - Polyethylene Glycol 3350 17gm / 1 scoopful by mouth once a day every 24 hours as needed for constipation
Nephro-Vite - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 0.8 mg / 1 tablet by mouth once a day for supplement
Novolog - Insulin Aspart Recombinant 100 unit/ml / inject 1 unit subcutaneous after meal for Type 1 diabetes mellitus
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg / 1 tablet by mouth as necessary every 6 hours as needed for Severe pain (score 7-10)
Senna S - Senna 8.6-50 mg / 1 tablet by mouth once a day every 24 hours as needed for constipation

14. DME and Supplies:

diabetic supplies, rolling walker, wheelchair, , wound care supplies, 4 wheeled walker

15. Safety Measures:

wheelchair precautions, standard precautions, hand rails, fall precautions, diabetic precautions, , , smoke detectors , medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, supervision at all times, sharps precautions, bathroom safety, activity supervision, non-weight bearing LLE

16. Nutrition:

diabetic

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Amputation, Legally Blind, Endurance

18.B. Activities Permitted

Up As Tolerated, Exercises Prescribed, Wheelchair, Transfer bed/Chair

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

20. Prognosis: good

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 Infection and inflammatory reaction due to internal fixation device of other site, initial encounter, 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 04/12/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Chaitanya Ravi
5400 OLD COURT ROAD
RANDALLSTOWN, MD 21133
PHONE: 410-521-4211 FAX: 14105210627 NPI: 1376504027

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 : 03/04/2026

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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Clinical Condition Requiring Homecare:

The patient is a 35-year-old male status post left ankle arthrodesis, Achilles tenotomy, Steindler stripping, and placement of a left bone stimulatory implant, currently with an external ORIF fixator in place on the left foot. The patient requires daily wound and pin site care, as well as management of multiple unstageable wounds on the left foot. Coordination of care was completed with Heidi at Dr. Daniels' orthopedic office, resulting in an update to wound care orders: pin sites are now to be cleansed with betadine and dressed with xeroform rather than calcium alginate. The patient's past medical history is significant for end-stage renal disease on hemodialysis (scheduled Tuesday, Thursday, and Saturday), anemia, diabetes mellitus, hyperkalemia, hypertension, bilateral blindness, major depressive disorder, and anxiety. The patient resides at home with his mother in a first-floor apartment, and all prescribed medications are available in the home. He is designated as full code with no known drug allergies. Functionally, the patient is non-weight bearing on the left lower extremity and utilizes a wheelchair for mobility. Despite education on safety and fall prevention, the patient refuses to use a bedside commode or urinal and instead crawls to the bathroom, kneeling to void or have bowel movements. The right foot is also compromised due to deformity from a prior toe amputation, further increasing fall and injury risk. A knee scooter was provided; however, the patient reports difficulty maneuvering it within the apartment and declines its use. Skilled nursing visits are to be scheduled on non-dialysis days (Monday, Wednesday, and Friday) to accommodate the patient's treatment regimen. Ongoing education has been provided regarding mobility safety, proper wound care, and adherence to treatment recommendations. The plan of care includes continued skilled nursing for wound management, monitoring for signs of infection or complications, reinforcement of safety strategies, and coordination with the orthopedic team and dialysis schedule.
 Date of Order 04/12/2026 Orders Physician Face-to-Face Date: 03/04/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat HHA daily adl's due to Infection and inflammatory reaction due to internal fixation device of other site, initial encounter 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 Physician Ravi, Chaitanya

SN Careplans

SN WK1: 2 (04/12/26-04/18/26) ,WK2: 1 (04/19/26-04/25/26) ,WK3: 1 (04/26/26-05/02/26) ,WK4: 1 (05/03/26-05/09/26) ,WK5: 1 (05/10/26-05/16/26)

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), 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 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, 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 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:MOLST

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M1720 - Anxiety, M2102c - Med Admin, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102d - Caregiver Performs

SN Goals

PATIENT-STATED GOAL: Patient states he wants to have his left foot wound heal so he can get around easier without the external fixator.

GOALS
patient/caregiver recalls
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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 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
* 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
* 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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/12/2026

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Admin, M2020 - Oral Med Management, M2102 - Patient Supervision, M2102a - Caregiver Performs Treatment, M1033 - Unintentional Weight Loss, M1400 - Dyspnea, dependent edema, limited strength, limited range of motion, muscle weakness, poor muscle tone, swelling of affected area, limited endurance, daytime fatigue, balance deficit, difficulty sleeping, Pain Interference with ADLs, Pain Effect on Sleep, B1000 - Vision Deficit, loss of appetite, open sores/lesions, swell/redness surround. skin, rough/scaly/cracked skin, red/tender pressure points, #1 - Observable Surgical Wound - Other - Left foot - Patient has an ORIF in place on his left foot., #2 - Diabetic Ulcer - Other - Left heel - , #3 - Diabetic Ulcer - Other - plantar fascia - , #4 - Diabetic Ulcer - Other - 5th metatarsal head - , #5 - Other - Other - LEFT DORSUM - , #6 - Other - Other - Left Distal Hallux - , #7 - Other - Other - Anterior left leg - Wound on left anterior left leg

PROCEDURES: physician-ordered wound care: #2 - Diabetic Ulcer - Other - Left heel -: Paint wound with betadine daily and leave OTA., physician-ordered wound care: #7 - Other - Other - Anterior left leg - Wound on left anterior left leg: Paint wound with betadine daily and leave OTA., physician-ordered wound care: #6 - Other - Other - Left Distal Hallux -: Paint wound with betadine daily and leave OTA., physician-ordered wound care: #5 - Other - Other - LEFT DORSUM -: Paint wound with betadine daily and leave OTA., physician-ordered wound care: #4 - Diabetic Ulcer - Other - 5th metatarsal head -: Paint wound with betadine daily and leave OTA., physician-ordered wound care: #3 - Diabetic Ulcer - Other - plantar fascia -: Paint wound with betadine daily and leave OTA., physician-ordered wound care: #1 - Observable Surgical Wound - Other - Left foot - Patient has an ORIF in place on his left foot.: Clean leftlower leg external fixator displacement sites with normal saline and apply calcium alginate, cover with gauze, wrap with kling and ACE bandage., physician-ordered wound care: #1 - Observable Surgical Wound - Other - Left foot - Patient has an ORIF in place on his left foot.: Clean left lower leg external fixator displacement sites with normal saline and apply calcium alginate, cover with gauze, wrap with Kling and ACE bandage., cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange resources for vision-impaired, 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, * 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, caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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