

Home Health Certification and Plan of Care				Order ID: 1150/21447	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
82250344		08/19/2026		From: 08/19/2026 To: 10/17/2026	
4. Medical Record No.		5. Provider No.			
29111		217058			
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Lawrence Ogle 607 Pennsylvania Ave Apt 408, BALTIMORE, MD 21201- 443-400-4697			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		

8. DOB 02/11/1955			9.Sex Male			10. Medications: Dose/Frequency/Route (N)ew (C)hanged							
11. ICD C20.		Principal Diagnosis Malignant neoplasm of rectum				Date 08/19/26		Pyridostigmine Bromide - Pyridostigmine Bromide 30 MG / 1 Tablet by mouth every 3 hours for myasthenia gravis Metoprolol Tartrate - Metoprolol Tartrate 50 MG / 1 Tablet by mouth twice a day for HTN Hold for SBP less than 100. HR less than 60 ASPIRIN Chewable 81 MG / 1 Tablet by mouth once a day for CVA Prophylaxis Thiamine Hydrochloride - Thiamine Hydrochloride 100 MG / 1 Tablet by mouth once a day for Vitamin supplement MULTIVITAMIN Give 1 tablet by mouth once a day for Vitamin supplement Folic Acid - Folic Acid 1 MG / 1 Tablet by mouth once a day for supplement MONTELUKAST SODIUM 10 MG / 1 Tablet by mouth once a day for ASTHMA Pantoprazole Sodium - Pantoprazole Sodium Delayed Release 40 MG / 1 Tablet by mouth twice a day for GERD Atorvastatin Calcium - Atorvastatin Calcium 80 MG / 1 Tablet by mouth at bedtime for HYPERLIPIDEMIA MELATONIN 5 MG / 1 Tablet by mouth at bedtime for Insomnia ACETAMINOPHEN 325 mg/tablet / Give 2 tablet by mouth as necessary every 6 hours for Pain. Scale 1-4 Tylenol not to exceed 4gm in 24 hours Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 MG / 1 Capsule by mouth in the evening for BPH METHOCARBAMOL 750 MG / 1 Tablet by mouth as necessary every 8 hours for Muscle Spasm/pain 3x per day prn Colace - Docusate Sodium 100 mg by mouth once a day Bowel regimen Symbicort - Budesonide: Formoterol Fumarate Dihydrate 0.08 mg/inh;0.0045 mg/inh 0.08mg inhalant once a day Asthma Accuneb - Albuterol Sulfate eq 0.021 perc base 21 inhalant as necessary Every 4 hour as needed for breathing Astelin - Azelastine Hydrochloride eq 0.125 mg base/spray 9.125 inhalant once a day Allergy					
13. ICD N32.1		Other Pertinent Diagnoses Vesicointestinal fistula				Date 08/19/26							
G70.00		Myasthenia gravis without (acute) exacerbation				08/19/26							
I50.32		Chronic diastolic (congestive) heart failure				08/19/26							
I70.0		Atherosclerosis of aorta				08/19/26							
I25.10		Athscl heart disease of native coronary artery w/o ang pctrs				08/19/26							
J45.909		Unspecified asthma uncomplicated				08/19/26							
E78.5		Hyperlipidemia unspecified				08/19/26							
G56.03		Carpal tunnel syndrome bilateral upper limbs				08/19/26							
I25.2		Old myocardial infarction				08/19/26							
M85.80		Oth disrd of bone density and structure unspecified site				08/19/26							
G47.00		Insomnia unspecified				08/19/26							
F10.20		Alcohol dependence uncomplicated				08/19/26							
Z93.3		Colostomy status				08/19/26							
Z87.440		Personal history of urinary (tract) infections				08/19/26							
Z79.82		Long term (current) use of aspirin				08/19/26							
Z95.1		Presence of aortocoronary bypass graft				08/19/26							
Z87.891		Personal history of nicotine dependence				08/19/26							
Z91.81		History of falling				08/19/26							
14. DME and Supplies: cane, urinary/catheter supplies, walker, ostomy supplies, nebulizer, 4 wheeled walker							15. Safety Measures: walker precautions, supervision at all times, standard precautions, medication safety, fall precautions, ambulates with device, ambulates with assistance, activity supervision						
16. Nutrition: low sodium, low cholesterol							17. Allergies: ace inhibitors						
18.A. Functional Limitations Dyspnea With Minimal Exertion, Ambulation, Endurance							18.B. Activities Permitted Walker, Cane, Up As Tolerated						
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: No													
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 Malignant neoplasm of rectum, 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: <p class="p">Start of care (SOC) was completed for a 71-year-old male recently discharged from skilled nursing rehabilitation following hospitalization related to rectal cancer, colostomy placement, and a vesicointestinal fistula, with a significant medical history including myasthenia gravis, CHF, CAD, prior CABG and NSTEMI, asthma, hyperlipidemia, osteopenia, bilateral total hip arthroplasties, history of falls, Foley catheter use with recent UTI, insomnia, and severe alcohol use disorder. Consents were signed with understanding. The patient lives alone in an elevator-accessible apartment that was noted to be significantly cluttered, with stool contamination observed in multiple areas, particularly the bathroom, and he reports having no regular caregiver other than a niece who resides out of state. A colostomy bag was noted to the left abdomen and a Foley catheter with drainage bag was intact. The patient demonstrates difficulty managing his current medical and self-care needs and presents with decreased standing balance, standing tolerance, bilateral upper-extremity strength, activity tolerance, functional mobility, and ability to perform self-care and transfers independently. He ambulates with a rollator and has an increased fall risk, making it a taxing effort to leave the home. Following a recent fall requiring EMS transport, imaging was negative for acute fracture or intracranial bleeding; bruising to the forehead and periorbital areas and an abrasion to the bridge of the nose were noted without active drainage or abnormal bleeding. Vital signs were stable, with BP 132/70, and no additional falls were reported on the day of assessment. Medications were reviewed, and education was provided regarding medication actions and side effects, inhaler and nebulizer use, Foley and UTI precautions, colostomy management, fall prevention, home safety, and the importance of follow-up care. The patient reported pain rated 7-8/10 and poor sleep; melatonin was prescribed for insomnia, and cefpodoxime 200 mg twice daily for 7 days was prescribed for infection management. The patient was instructed to

23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 08/19/2026		25. Date HHA Received Signed POT	
24. Physician's Name and Address Linda Ataifo 815 E. Pratt St Baltimore, MD 21202 PHONE: 4106375700 FAX: NPI: 1609371905		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 : 08/10/2026	
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 5	

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follow up with his PCP on 8/28/2026 for post-discharge evaluation and medication reconciliation and to resume oncology follow-up. Skilled nursing and occupational therapy services are indicated to monitor his medical status, provide colostomy and Foley care education, address medication management and safety concerns, improve strength, balance, endurance, self-care, transfers, and functional mobility, and reduce the risk of falls, complications, and rehospitalization.

16 Date of Order

16 Physician Face-to-Face Date: 08/10/2026

16 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat dx: Malignant neoplasm of rectum

16 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home

16 PT Eval Notes:

16 OT Eval Notes:

16 Physician:

Ataifo, Linda

SN Careplans

SN WK1: 1 (08/19/26-08/22/26) ,WK2: 1 (08/23/26-08/29/26) ,WK3: 1 (08/30/26-09/05/26) ,WK4: 1 (09/06/26-09/12/26) ,WK5: 1 (09/13/26-09/19/26) ,WK6: 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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 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

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 ; 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

SN Goals

PATIENT-STATED GOAL: To have foley "out"

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 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

- * 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

- * prevention including increase fluid intake
- * increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
- * perineal hygiene
- * 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

patient has adequate heating

Signature of Physician:	Date
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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. No open wounds noted; 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. Colostomy to left side abdomen with Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing. Colostomy to left side abdomen with Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration; 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. 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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. Colostomy to left side abdomen Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing. Colostomy to left side abdomen with Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration Advance Directive: YES 08/19/2026 Problems : cluttered/soiled living area (CM) inadequate heating (CM) M1600 - UTI M1610 - Urinary Catheter M1033 - Exhaustion Pain Effect on Sleep Pain Interference with Therapy activities Pain Interference with ADLs M1400 - Dyspnea M2020 - Oral Med Management weight gain > 2lb/24 h OR 5lb/1 wk swelling in legs/around eyes	patient's living environment is clean/uncluttered patient is adequately supervised meal preparation is available to patient for all meals caregiver administers and/or packages medications appropriately caregiver performs medical/rehabilitation treatments with adequate competence
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coughing abn cholesterol > 200 mg/dL abnormal blood pressure balance deficit poor muscle tone muscle spasms muscle weakness limited endurance limited strength decreased urine output heartburn/indigestion loss of appetite bruising/discoloration discolored patches of skin red/tender pressure points meal preparation M2102c - Med Admin M2102f - Patient Supervision M2102d - Caregiver Performs Treatment	
PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, apply collection/fistula pouch: No orders, ostomy care & irrigation: No orders, monitor intake & output, catheter change, care & irrigation: No orders, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals, coordinate/arrange repair of inadequate heating, coordinate/arrange for maintenance of clean/uncluttered living area 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, * 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, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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, patient has adequate heating, patient's living environment is clean/uncluttered, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence	

PT Careplans PT WK2: 1 (08/23/26-08/29/26) ,WK3: 1 (08/30/26-09/05/26) ,WK4: 1 (09/06/26-09/12/26) ,WK5: 1 (09/13/26-09/19/26) ,WK6: 1 (09/20/26-09/26/26) ,WK7: 1 (09/27/26-10/03/26) 08/24/2026 Problems : 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 PROCEDURES: home exercise program: Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Knee extension, ankle pumps, 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 - 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	PT Goals PATIENT-STATED GOAL: To be able to get out of the house by myself and feel stronger GOALS Chair to Bed to Chair - 06. Independent Toilet Transfer - 06. Independent 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
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OT Careplans	OT Goals
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