Home Health Certification and Plan of Care

Order ID: 1150/21454

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
5NJ4TN1KN86	08/20/2026	From: 08/20/2026 To: 10/18/2026	29339	217058

6. Patient's Name and Address

Edwin Collier
12903 Cunninghill Cove,
Middle river, MD 21220-
443-567-2599

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 02/02/1950 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
G31.83	Neurocognitive disorder with Lewy bodies	08/20/26

13. ICD	Other Pertinent Diagnoses	Date
F02.818	Dem in oth dis classd elswhr unsp sev with oth beh distrb	08/20/26
F02.82	Dem in other dis classd elswhr unsp sev with psych distrb	08/20/26
F02.84	Dem in other dis classd elswhr unsp severity with anxiety	08/20/26
F32.9	Major depressive disorder single episode unspecified	08/20/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	08/20/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	08/20/26
N18.30	Chronic kidney disease stage 3 unspecified	08/20/26
D63.1	Anemia in chronic kidney disease	08/20/26
D69.6	Thrombocytopenia unspecified	08/20/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	08/20/26
M51.369	Oth intvrt disc degen lum rgn w/o lum bck or lw extrm painOth intvrt disc degen lum rgn w/o lum bck or lw extrm pain	08/20/26
E78.00	Pure hypercholesterolemia unspecified	08/20/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	08/20/26
E11.319	Type 2 diabetes w unsp diabetic rtnop w/o macular edema	08/20/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	08/20/26
M48.00	Spinal stenosis site unspecified	08/20/26
E53.8	Deficiency of other specified B group vitamins	08/20/26
K21.9	Gastro-esophageal reflux disease without esophagitis	08/20/26
E55.9	Vitamin D deficiency unspecified	08/20/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	08/20/26
Z85.72	Personal history of non-Hodgkin lymphomas	08/20/26
Z79.4	Long term (current) use of insulin	08/20/26
Z79.82	Long term (current) use of aspirin	08/20/26
Z87.891	Personal history of nicotine dependence	08/20/26

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

Vitamin D-3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 125 MCG (5000 UT) / 1 Tablet by mouth one time a day for Supplement
Tylenol - Acetaminophen 325 mg/tablet / Give 2 tablet by mouth every 6 hours for Pain
Trazodone Hydrochloride - Trazodone Hydrochloride 100 mg/tablet / Give 2 tablet by mouth at bedtime for depression
Sertraline Hcl - Sertraline Hydrochloride 25 MG / 1 Tablet by mouth once a day for depression Give sertraline 25 mg along with sertraline 100 mg equal 125 mg PO daily.
Sertraline Hcl - Sertraline Hydrochloride 100 MG / 1 Tablet by mouth one time a day for depression. Give sertraline 100 mg along with sertraline 25 mg to equal 125 mg PO daily.
Neurontin - Gabapentin 100 mg/capsule / Give 2 capsule by mouth at bedtime for Nerve pain
Metoprolol Tartrate - Metoprolol Tartrate 50 MG / 1 Tablet by mouth two times a day for HTN Hold for SBP less than 110 or HR less than 50
LOSARTAN POTASSIUM 25 MG / 1 Tablet by mouth one time a day for HTN hold for SBP less than 110
Icosapent Ethyl 1 gm/capsule / Give 2 capsule by mouth twice a day for Hyperglyceridemia
FLOMAX 0.4 MG / 1 Capsule by mouth at bedtime for kidney stone
Finerenone 10 MG / 1 Tablet by mouth once a day related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65); CHRONIC KIDNEY DISEASE, STAGE 3 UNSPECIFIED (N18.3)
Ferrous Sulfate - Ferrous Sulfate: Folic Acid Dried Extended Release 160 (50 Fe) MG / 1 Tablet by mouth once a day for Anemia
DONEPEZIL HYDROCHLORIDE 10 MG Tablet by mouth one time a day for dementia
Bupropion Hydrochloride - Bupropion Hydrochloride Extended Release 12 Hour 150 MG / 1 Tablet by mouth twice a day for Depression
Brexpiprazole 0.5 MG / 1 Tablet by mouth once a day for Dementia with agitation
Atorvastatin Calcium - Atorvastatin Calcium 80 MG / 1 Tablet by mouth one time a day for Hyperlipidemia
ASPIRIN 0 Chewable 81 MG / 1 Tablet by mouth one time a day for TIA prophylaxis related to CEREBRAL INFARCTION DUE TO UNSPECIFIED OCCLUSION OR STENOSIS OF UNSPECIFIED CEREBRAL ARTERY (I63.50)
Amlodipine Besylate - Amlodipine Besylate 5 MG / 1 Tablet by mouth one time a day for HTN Hold for SBP less than 110
ESOMEPRAZOLE MAGNESIUM Delayed Release 40 MG / 1 Capsule Oral one time a day for GERD
Tresiba - Insulin Degludec Subcutaneous Solution 100 UNT/ML / Inject 25 unit subcutaneous one time a day for DM

14. DME and Supplies:

wheelchair, bath bench, walker, grab bars, cane

15. Safety Measures:

walker precautions, medication safety, fall precautions, standard precautions, wheelchair precautions, hand rails, bathroom safety

16. Nutrition:

cardiac diet, diabetic

17. Allergies:

augmentin

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

No Restrictions

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: 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!4. Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects), HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

22.B.Discharge Plans

patient will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Neurocognitive disorder with lewy bodies, 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 08/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Mohammad Rahnama
9512 HARFORD ROAD
PARKVILLE, MD 21234
PHONE: 410-665-4400 FAX: 14106612420 NPI: 1952458739

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 : 08/12/2026

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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6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Edwin Collier 12903 Cunninghill Cove, Middle river, MD 21220- 443-567-2599	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Clinical Condition Requiring Homecare:

The patient is a 76-year-old male with a significant past medical history of cognitive impairment, Lewy body dementia with behavioral disturbance, major depressive disorder, type 2 diabetes mellitus, hypertension, hyperlipidemia, and chronic kidney disease stage 3. The patient recently experienced a physical and verbal altercation with his wife during which he struck her with a cane and made threats to kill her after she restricted his driving privileges. EMS was contacted, and the patient was transported to the hospital for evaluation. Psychiatry evaluated the patient and recommended close monitoring due to episodes of agitation, with consideration for admission to a geriatric psychiatric unit if agitation persisted. Due to physical debility, the patient was evaluated by physical therapy and subsequently transferred to a rehabilitation facility for continued care. The patient has now returned home and resides with his wife. At the start-of-care assessment, the patient was alert and oriented x3 and correctly recalled three words (bed, blue, socks) without cues. He answered assessment questions appropriately; however, intermittent agitation was observed, including verbal exchanges with his daughter who was present during the visit. The patient denied pain, shortness of breath, headache, nausea, or vomiting. He ambulates without an assistive device but requires skilled physical therapy intervention because he refuses to use an assistive device despite his mobility deficits. His skin was warm and intact. He currently requires assistance with some activities of daily living (ADLs). Medication reconciliation and review were completed with the patient's wife and daughter. The patient is compliant with his medications when they are administered by his wife, although he repeatedly asks what the medications are for, indicating the need for continued medication education and caregiver oversight. The patient also presents with functional deficits requiring skilled occupational therapy following hospitalization and subacute rehabilitation secondary to altered mental status. Prior to hospitalization, he resided with his spouse in a single-family home and required minimal assistance with basic self-care tasks, while functional transfers and ambulation were completed with supervision. Currently, the patient demonstrates decreased standing balance, standing tolerance, bilateral upper-extremity strength, and overall activity tolerance, resulting in decreased independence with self-care, functional transfers, and functional ambulation. Skilled OT services are indicated to address these deficits, improve safety and functional performance, and facilitate progression toward the patient's prior level of functional independence. Skilled PT and OT interventions should include functional mobility and transfer training, strengthening, balance and endurance activities, ADL retraining, safety awareness, and reinforcement of appropriate use of assistive devices. Education and supportive counseling were provided to the patient's wife and daughter regarding the importance of continued family support, caregiver communication, recognition of potential stressors contributing to agitation, and strategies to reduce caregiver strain. The patient's wife reported significant difficulty managing his behavioral symptoms and identified herself as a frequent source of conflict due to the patient's illness-related expectations and accusations. She reported that the patient expects her to dress in heels despite her knee problems and becomes suspicious and accuses her of infidelity if she leaves the home and does not return within approximately 10 minutes. The wife was educated that these behaviors and statements may be related to the patient's underlying illness, while also acknowledging the emotional impact these behaviors have on her. She was encouraged to make time for herself and prioritize her own health and well-being so that she can continue to safely support the patient. Continued skilled home health services are warranted for monitoring of cognitive and behavioral status, medication management and education, caregiver education and support, fall and safety risk reduction, and skilled PT/OT intervention to improve strength, balance, endurance, ADL performance, functional transfers, and safe ambulation while promoting the highest practical level of independence in the home.
 Date of Order 08/20/2026 Orders Physician Face-to-Face Date: 08/12/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Neurocognitive disorder with lewy bodies 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 OT Eval Notes:
 Physician Rahnama, Mohammad

SN Careplans

SN WK1: 1 (08/20/26-08/22/26) ,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)

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: 1. Non-agency caregiver(s) currently 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, 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; 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

SN Goals

PATIENT-STATED GOAL: To be stronger and more mobile.

GOALS
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
* 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
* 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
* 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
* 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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/20/2026

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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.

; 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:SEE MOLST

08/21/2026 Problems : M1720 - Anxiety
M1745 - Behavioral Issues
M1033 - Exhaustion
M1400 - Dyspnea
M2020 - Oral Med Management
abnormal blood pressure
balance deficit
muscle weakness
abnormal BS < 70/140 > mg/dL
D0160 - Depression

PROCEDURES: coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor

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, * 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, * 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, * 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

OT Careplans

OT WK1: 1 (08/20/26-08/22/26) ,WK3: 1 (08/30/26-09/05/26) ,WK5: 1 (09/13/26-09/19/26)

08/21/2026 Problems : GG0170G1 - Car Transfer
GG0130A1 - Eating
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130F1 - Upper Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170E1 - Chair to Bed to Chair
M1400 - Dyspnea
GG0170P1 - Picking Up Object
GG0170O1 - 12 Steps
GG0170N1 - 4 Steps
GG0170M1 - 1 - Step (curb)
GG0170K1 - Walk 150 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170I1 - Walk 10 Feet
GG0170F1 - Toilet Transfer
GG0170D1 - Sit to Stand

PROCEDURES: Medication Review : Medication reviewed with caregiver with all medications in the home, home exercise program: Bilateral UE triceps extensions, biceps curls and armchair 2-3 sets 8-12 reps, equipment training, work simplification/energy conservation, transfers training, 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, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04.

OT Goals

PATIENT-STATED GOAL: I want to stop walking

GOALS
Toilet Transfer - 06. Independent

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

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

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

Car Transfer - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 04. Supervision or touching assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Signature of Physician:

Date

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

Date
08/20/2026

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Supervision or touching assistance, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 05. Setup or clean-up assistance	Lower Body Dressing - 05. Setup or clean-up assistance Don/Doff Footwear - 05. Setup or clean-up assistance Eating - 05. Setup or clean-up assistance

Signature of Physician:	Date
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