Home Health Certification and Plan of Care

Order ID: 1150/21505

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
30922784370	08/19/2026	From: 08/19/2026 To: 10/17/2026	28773	217058

6. Patient's Name and Address

Simon Alesin
3440 Associated Way Apt 321,
OWINGS MILLS, MD 21117-
443-983-9365

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 04/02/1937 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I95.89	Other hypotension	08/19/26

13. ICD	Other Pertinent Diagnoses	Date
N39.0	Urinary tract infection site not specified	08/19/26
I48.19	Other persistent atrial fibrillation	08/19/26
I10.	Essential (primary) hypertension	08/19/26
E78.49	Other hyperlipidemia	08/19/26
D63.8	Anemia in other chronic diseases classified elsewhere	08/19/26
E05.00	Thyrotoxicosis w diffuse goiter w/o thyrotoxic crisis	08/19/26
N40.1	Benign prostatic hyperplasia with lower urinary tract symp	08/19/26
R35.1	Nocturia	08/19/26
D51.0	Vitamin B12 defic anemia due to intrinsic factor deficiency	08/19/26
F32.A	Depression unspecified	08/19/26
H91.90	Unspecified hearing loss unspecified ear	08/19/26
M62.89	Other specified disorders of muscle	08/19/26
E55.9	Vitamin D deficiency unspecified	08/19/26
K59.09	Other constipation	08/19/26
R13.19	Other dysphagia	08/19/26
R41.0	Disorientation unspecified	08/19/26
R41.89	Oth symptoms and signs w cognitive functions and awareness	08/19/26
Z79.01	Long term (current) use of anticoagulants	08/19/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	08/19/26
Z91.81	History of falling	08/19/26

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

CYANOCOBALAMIN Solution 1000 MCG/ML / Inject 1 ml subcutaneously one time a day every 14 day(s) for Pernicious anemia
DUTASTERIDE 0.5 MG / 1 Capsule by mouth at bedtime for BPH
ELIQUIS 5 MG / 1 Tablet by mouth two times a day for Atrial Fibrillation
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1.25 MG (50000 UT) / 1 Capsule by mouth one time a day every Wed for Vitamin D Deficiency
METHIMAZOLE 5 mg/tablet / Give 0.5 tablet by mouth one time a day for Graves Disease
Mirtazapine - Mirtazapine 7.5 mg by mouth at bedtime
ROSUVASTATIN CALCIUM 10 MG / 1 Tablet by mouth at bedtime for Hyperlipidemia
FOLIC ACID 1 MG / 1 Tablet by mouth one time a day for supplement
MIRALAX 0 Give 17 gram by mouth one time a day for Constipation Mix in 4 to 8 ounces of fluid
MIDODRINE HYDROCHLORIDE 5 MG / 1 Tablet by mouth three times a day for Hypotension HOLD FOR SBP GREATER THAN 130
Propranolol Hydrochloride - Propranolol Hydrochloride 10 MG / 1 Tablet by mouth two times a day for Hypertension HOLD FOR SBP <110 OR HR<60

14. DME and Supplies:

bath bench, rolling walker, cane

15. Safety Measures:

cardiac precautions, ambulates with device, medical alert/lifeline, fall precautions, medication safety, walker precautions, bathroom safety, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Hearing, Ambulation

18.B. Activities Permitted

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: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., 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
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Other hypotension, 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 an 89-year-old Russian-speaking male admitted to home health following an unwitnessed fall that resulted in a brief acute-care hospitalization followed by a skilled nursing facility stay. His significant past medical history includes atrial fibrillation managed with Eliquis, supraventricular tachycardia (SVT), syncope, hypertension, hyperlipidemia, Graves' disease, benign prostatic hyperplasia (BPH) status post prostate surgery, pernicious anemia, depression, hearing impairment, gait instability, left basilar artery stenosis with a history of stroke in 2017, and left hip surgery in 2023. Prior to his recent hospitalization, the patient lived alone in a senior apartment building and was ambulatory with a rolling walker/rollator and supervision. His family is temporarily staying with him during his recovery. Upon arrival, the patient was observed sitting upright on the living room couch with his son-in-law present and assisting with communication and medication review. Vital signs were obtained and were stable: temperature 98.4F, pulse 67 bpm at the left radial site, blood pressure 125/73 mmHg in the right arm, and oxygen saturation 99% on room air. The patient reports a bowel movement this morning. He complains of discomfort related to a left inguinal hernia and is wearing a compression/support belt for comfort and support; his son-in-law reports that the hernia has been symptomatic since the patient's hospitalization. The patient also reports persistent dizziness that fluctuates in intensity, described as mild at the time of assessment. He denies nausea, vomiting, chest pain, or shortness of breath. Respiratory assessment revealed lungs clear to auscultation, bowel sounds were audible, and peripheral pulses were palpable. Skin was warm and generally intact, with poor skin turgor, areas of erythema, and significant bruising/abrasions noted over the bilateral knees; photographs were obtained of the abrasions to the outer aspects of both knees. A tremor was noted in the right hand. The patient wears an upper denture set. Medication reconciliation and review were completed with the patient and son-in-law, and the patient was admitted to home health services for continued skilled assessment, monitoring, education, and rehabilitation. The physical therapy evaluation was completed. The patient demonstrates significant functional decline following his recent hospitalization and fall, with bilateral lower-extremity weakness measured at 3-/5 on manual muscle testing. He currently requires minimal assistance for sit-to-stand and other transfers and for short-distance ambulation using a rolling walker, with verbal cues required to improve upright trunk posture and safety during mobility. His impaired strength, balance deficits, dizziness, gait instability, and history of recurrent falls place him at increased risk for additional falls and injury. Skilled physical therapy is indicated to address lower-extremity weakness, balance impairment, gait mechanics, transfer ability, safety awareness, and functional endurance, with the goal of improving independence and returning the patient toward his prior level of function. The occupational

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

ELENA VOLKOV
1838 Green Tree Rd
Pikesville, MD 21208
PHONE: 4434710460 FAX: 14105842255 NPI: 1750419917

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 : 08/03/2026

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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therapy evaluation was also completed. The patient currently ambulates with a rollator and requires contact guard assistance for functional mobility, sit-to-stand transfers, and toilet transfers. He is able to bathe himself in the shower with supervision and can don socks and pants, but requires minimal assistance with donning his shirt. Bilateral upper-extremity strength is reduced at approximately 4-/5 on manual muscle testing, contributing to decreased functional performance with activities of daily living. The patient demonstrates impaired safety and remains a significant fall risk given his recent hospitalization, history of multiple falls, gait instability, weakness, dizziness, and tendency to perform activities according to his own established methods despite safety recommendations. Skilled OT services are warranted to address upper-extremity strength, ADL performance, transfer safety, functional mobility, fall prevention, and adaptive strategies to maximize safety and independence within the home environment. Continued skilled nursing, PT, and OT services are recommended as part of the plan of care, with ongoing monitoring of the patient's cardiopulmonary status, dizziness, skin integrity and bilateral knee abrasions, hernia-related discomfort, medication regimen, functional status, and fall risk. Patient and family will continue to receive education regarding medication adherence, safe transfers and ambulation, use of assistive devices, fall-prevention strategies, symptom monitoring, and when to report changes in condition to the appropriate healthcare provider.
 Date of Order 08/19/2026 Orders Physician Face-to-Face Date: 08/03/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Other hypotension 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: PT Eval Notes:
 Physician Volkov, Elena

SN Careplans

SN WK1: 1 (08/19/26-08/22/26) ,WK2: 2 (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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 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,.
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:Living Will

08/27/2026 Problems : #2 - Abrasion - Anterior Left Knee -
#1 - Abrasion - Anterior Right Knee -
M1600 - UTI
M1033 - Exhaustion
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
dizziness/syncope
involuntary movement of extremity
balance deficit
weak hand grips
limited strength
limited endurance
paller

SN Goals

PATIENT-STATED GOAL: "I want my balance with walking back."

GOALS
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 minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* 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

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
* 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
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* 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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/19/2026

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pain
bruising/discoloration
B0200 - Hearing Deficit
B1000 - Vision Deficit
D0160 - Depression

PROCEDURES: physician-ordered wound care: #2 - Abrasion - Anterior Left Knee -, physician-ordered wound care: #1 - Abrasion - Anterior Right Knee -, apply anti-embolitic stockings, monitor intake & output

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, * 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, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, 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

PT Careplans

PT 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) ,WK7: 1 (09/27/26-10/03/26) ,WK8: 1 (10/04/26-10/10/26)

08/20/2026 Problems : Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
GG0170D1 - Sit to Stand
GG0170F1 - Toilet 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
GG0170G1 - Car Transfer
GG0170E1 - Chair to Bed to Chair
GG0170L1 - Walk 10 ft on Uneven Surface

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, cough/deep breathing exercises, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed, gait training/stair training, transfers training

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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 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, 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

PT Goals

PATIENT-STATED GOAL: To be able to walk without help

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

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

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

Toilet Transfer - 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

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

OT Careplans

OT 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)

08/21/2026 Problems : M1400
GG0130B1 - Oral Hygiene
GG0130C1 - Toileting Hygiene
GG0130E1 - Shower/Bathe Self
GG0130F1 - Upper Body Dressing

OT Goals

PATIENT-STATED GOAL: Family wants patient to get up safer from sitting surfaces

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
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GG0130G1 - Lower Body Dressing
GG0130H1 - Don/Doff Footwear
GG0130A1 - Eating

PROCEDURES: Therapeutic exercises : Using dumbbells or therabands to perform bilateral upper extremity muscle strength exercises, Transfer training: Sit to stand and toliet transfers, Functional ambulation : Using rollator, Patient/caregiver recalls related purpose and schedule of medications: Medication Review, cough/deep breathing exercises

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 - 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 - 06. Independent, Patient will demonstrates improved bilateral upper extremity muscle strength from 4-/5 mmt to 4+/5 mmt to improve Adls and transfers safely

Oral Hygiene - 06. Independent

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 - 06. Independent

Patient will demonstrates improved bilateral upper extremity muscle strength from 4-/5 mmt to 4+/5 mmt to improve Adls and transfers safely

Signature of Physician:	Date
	PAGE 4 of 4
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