Home Health Certification and Plan of Care

Order ID: 1150/21652

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
96308923	08/27/2026	From: 08/27/2026 To: 10/25/2026	29680	217058

6. Patient's Name and Address

Adrian Baty
11913 Tarragon Road Apt E,
REISTERSTOWN, MD 21136-
443-244-3718

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 12/08/1981 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.81	Encounter for orthopedic aftercare following surgical amp	08/27/26

13. ICD	Other Pertinent Diagnoses	Date
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	08/27/26
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	08/27/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	08/27/26
N18.6	End stage renal disease	08/27/26
D63.1	Anemia in chronic kidney disease	08/27/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	08/27/26
F33.0	Major depressive disorder recurrent mild	08/27/26
E21.3	Hyperparathyroidism unspecified	08/27/26
E11.319	Type 2 diabetes w unsp diabetic rtnop w/o macular edema	08/27/26
I25.2	Old myocardial infarction	08/27/26
E78.5	Hyperlipidemia unspecified	08/27/26
K59.00	Constipation unspecified	08/27/26
Z89.412	Acquired absence of left great toe	08/27/26
Z99.2	Dependence on renal dialysis	08/27/26
Z94.0	Kidney transplant status	08/27/26
Z79.4	Long term (current) use of insulin	08/27/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	08/27/26
Z79.82	Long term (current) use of aspirin	08/27/26
Z79.891	Long term (current) use of opiate analgesic	08/27/26

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

ACETAMINOPHEN 500mg/tablet / Take 2 tablets by mouth every 6 (six) hours as needed for Pain. For diagnoses: Kidney replaced by transplant, Immunosuppression
ASPIRIN 0 EC 81 MG / 1 Tablet by mouth daily
ATORVASTATIN 20 MG / 1 Tablet by mouth daily
CARVEDILOL 25 MG / 1 Tablet by mouth 2 (two) times daily.
Cetirizine Hydrochloride - Cetirizine Hydrochloride 10 MG / 1 Tablet by mouth once a day as needed for Allergies.
GABAPENTIN 300 MG capsule / Take 100 mg by mouth 2 (two) times daily.
Humalog Kwikpen - Insulin Lispro Recombinant 100 unit/mL subcutaneous three times a day Follow MEDIUM dose sliding scale with meals and once at bedtime.
insulin glargine-yfgn 100 unit/mL (3 mL) injection / Inject 10 Units subcutaneous in the evening
MYCOPHENOLATE MOFETIL 500 MG / 1 Tablet by mouth 2 (two) times daily.
Nifedipine - Nifedipine ER 30 MG / 1 Tablet by mouth as necessary daily, if Blood Pressure is greater than 140 after taking coreg.
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 0 Immediate Release 5 MG / 1 Tablet by mouth as necessary every 4 hours
Pantoprazole - Pantoprazole Sodium EC 40 MG / 1 Tablet by mouth as necessary daily
PREDNISONE 5 MG / 1 Tablet by mouth daily with breakfast. For diagnoses: Kidney replaced by transplant, Immunosuppression
TACROLIMUS 1 mg/capsule / Take 3 capsules by mouth in the morning AND 2 capsules (2 mg total) every evening. For diagnoses: Kidney replaced by transplant, Immunosuppression
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25 mcg (1,000 unit)/capsule / Take 2 capsules (2,000 Units total) by mouth once a day

14. DME and Supplies:

wound care supplies, diabetic supplies, cane, bath bench

15. Safety Measures:

medication safety, fall precautions, diabetic precautions, bleeding precautions, bathroom safety, anticoagulant precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

niacin penicillins

18.A. Functional Limitations

Ambulation, Amputation

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

20. Prognosis: good

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

Homebound status: After undergoing Amputation of the right great toe, 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 44-year-old male admitted to home health services following amputation of the right great toe. Past medical history is significant for end-stage renal disease (ESRD) secondary to diabetic/hypertensive nephropathy, status post deceased-donor kidney transplant (DDKT) in November 2024, STEMI, peritonitis while on peritoneal dialysis (PD), type 2 diabetes mellitus (T2DM), hypertension, peripheral arterial disease (PAD), depression, and hyperparathyroidism. The patient has a dialysis fistula in place that is no longer being used following kidney transplantation. Upon arrival to the home, the patient was alert and oriented and ambulating independently with a limp and some imbalance, using furniture for support as needed. Vital signs were within acceptable parameters: temperature 97.2F, pulse 87 bpm, oxygen saturation 97% on room air; height 5'9" and weight 174 lbs. Most recent blood glucose was 122 mg/dL this morning. The patient reports intermittent pain at the right great toe amputation site, described as shooting and throbbing and rated 7/10. He reports limiting his use of oxycodone in an effort to wean off the medication and reports experiencing dizziness with oxycodone doses. The patient was educated regarding use of Tylenol between oxycodone doses and encouraged to take two 500 mg tablets every 6 hours as needed, as he had been taking only one tablet at a time. The patient reports having his surgical dressing changed prior to discharge and has an upcoming appointment for dressing change in the office; he would like home health dressing changes performed on Tuesdays and Fridays. He was encouraged to request written dressing-care instructions and obtain dressing supplies from the office so the home health case manager can perform dressing changes and order additional supplies as needed. On assessment, lungs were clear to auscultation bilaterally, bowel sounds were active, peripheral pulses were palpable, and the right great toe amputation dressing was clean, dry, and intact. The patient reports intermittent epistaxis since receiving heparin during hospitalization, which has been decreasing and is primarily noted when he blows his nose. He denies shortness of breath or chest pain. Last bowel movement was this morning. The patient also reports increased sleeping and decreased appetite but denies suicidal thoughts. Allergies include PCN and niacin. Skilled home health nursing is indicated for continued assessment of the surgical amputation site, wound and dressing management, monitoring for complications and signs of infection, medication and pain management, diabetes monitoring, safety assessment related to dizziness and impaired balance, and ongoing patient education and reinforcement to support healing and prevent complications.
 Date of Order <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 08/27/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Sharon Chung
7670 Quarterfield Rd
Glen Bernie, MD 21061
PHONE: 410-508-7650 FAX: 1-410-508-7701 NPI: 1295026045

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 : 08/20/2026

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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14px;">08/27/2026 Orders Physician Face-to-Face Date: 08/20/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management due to Amputation of the right great toe 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 Chung, Sharon

SN Careplans

SN WK1: 1 (08/27/26-08/29/26) ,WK2: 1 (08/30/26-09/05/26) ,WK3: 1 (09/06/26-09/12/26) ,WK4: 1 (09/13/26-09/19/26) ,WK5: 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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 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:No Advance Directive on File

08/31/2026 Problems : #1 - Observable Surgical Wound - Anterior Right Foot -
D0700 - Social Isolation
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
Home Safety
dependent edema
balance deficit
limited endurance
loss of appetite
bruising/discoloration
D0160 - Depression

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Right Foot -, Medication review : Medications will be reviewed with patient at every visit., incentive spirometer, apply compression bandage, 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, * 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

SN Goals

PATIENT-STATED GOAL: "I don't want to lose anymore toes."

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

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

patient's living environment is clean/uncluttered

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/27/2026

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