Home Health Certification and Plan of Care

Order ID: 1150/21776

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
44801584700	09/01/2026	From: 09/01/2026 To: 10/30/2026	12347	217058

6. Patient's Name and Address

James Peay
124 West Franklin St,
BALTIMORE, MD 21201-
443-602-6118

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 09/15/1956 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	09/01/26

13. ICD	Other Pertinent Diagnoses	Date
I50.42	Chronic combined systolic and diastolic hrt fail	09/01/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	09/01/26
N18.30	Chronic kidney disease stage 3 unspecified	09/01/26
D63.1	Anemia in chronic kidney disease	09/01/26
I42.8	Other cardiomyopathies	09/01/26
I95.1	Orthostatic hypotension	09/01/26
J44.9	Chronic obstructive pulmonary disease unspecified	09/01/26
E78.5	Hyperlipidemia unspecified	09/01/26
M10.9	Gout unspecified	09/01/26
K21.9	Gastro-esophageal reflux disease without esophagitis	09/01/26
F43.21	Adjustment disorder with depressed mood	09/01/26
Z95.810	Presence of automatic (implantable) cardiac defibrillator	09/01/26
Z79.4	Long term (current) use of insulin	09/01/26
Z79.899	Other long term (current) drug therapy	09/01/26
Z79.82	Long term (current) use of aspirin	09/01/26

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

Jardiance - Empagliflozin 10 mg , take (10 mg) tablet by mouth once a day QDAY
PO
Lipitor - Atorvastatin Calcium 80 mg , take (80 mg) tablet by mouth at bedtime QHS
PO
Neurontin - Gabapentin 300 mg , take(300 mg) capsule by mouth three times a day TID
PO
Zetia - Ezetimibe 10 mg , take (10 mg) tablet by mouth once a day QDAY
PO
Atorvastatin - Atorvastatin Calcium 80 mg , take (80 mg) tablet by mouth once a day 80 mg daily
Breztri inhaler inhaler 2 puffs Inhalation , 2 puffs inhalant twice a day
Entresto - Sacubitril: Valsartan 24 mg/26 mg , take (24 mg/26 mg) tablet by mouth twice a day Entresto 24-26 BID
Spironolactone - Spironolactone 25 mg , take (25 mg) tablet by mouth once a day 25 mg daily
Insulin glargine 18 units 18 units , injection intravenous once a day Insulin glargine 18 units daily
Albuterol - Albuterol 90mcg , inhalation inhalant every 6 hours 90mcg inhaler every 6 hours PRN
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 10mg , take (10mg) tablet by mouth every 4 hours 10mg Q4H PRN
Eliquis - Apixaban 5mg by mouth twice a day
Ozempic 2mg/1.5ml intravenous once a week Ozempic weekly
Aspirin - Aspirin 81mg by mouth in the morning
Pantoprazole - Pantoprazole Sodium 40 mg 40mg by mouth once a day GERD
Digoxin - Digoxin 0.125 mg 0.125mg by mouth threee times per week MWF
Melatonin - Melatonin 3mg (2 tabs) by mouth at bedtime Insomnia
Senakot - Senna 8.6mg (2 tabs) by mouth in the evening PRN for constipation
Lasix - Furosemide 20 mg 20mg by mouth once a day Diuretic
Allopurinol - Allopurinol 100 mg 100mg by mouth once a day Gout
Novolog - Insulin Aspart Recombinant 8 units , injection subcutaneous three times a day AC
SUBQ with meals

14. DME and Supplies:

cane, 4 wheeled walker, reacher, rolling walker, wheelchair, walker

15. Safety Measures:

anticoagulant precautions, wheelchair precautions, walker precautions, supervision at all times, standard precautions, fall precautions, cardiac precautions, bleeding precautions, bathroom safety, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

diabetic, low cholesterol, cardiac diet

17. Allergies:

shellfish

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Endurance, Ambulation

18.B. Activities Permitted

Wheelchair, 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: Yes

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 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, 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 09/01/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Gregory LaLonde
800 Linden Avenue
Baltimore, MD 21201
PHONE: 4108563660 FAX: 14102258938 NPI: 1629569587

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 : 08/11/2026

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:

SOC completed with consents signed by the patient, who demonstrated understanding. The patient is a 69-year-old with a recent hospitalization and rehabilitation stay following LVAD placement related to heart failure/cardiomyopathy. Past medical history includes CHF, COPD, CKD, diabetes mellitus, anemia, hyperlipidemia, hypotension, gout, GERD, insomnia, and a history of defibrillator placement and right knee replacement. The patient is alert and oriented 3-4 and has a friend/caregiver, Barbara Hicks, available for support. The patient resides alone in an elevator-accessible senior apartment with no stairs and was previously independent with self-care, transfers, and functional ambulation. The LVAD access/surgical site is located on the right abdomen and is covered; no dressing-change instructions were available, and attempts to contact the provider for further instructions were unsuccessful. The LVAD motor was audible on chest auscultation, and the patient uses a portable battery source with a long connection cord; LVAD safety and fall-prevention measures were reviewed. The patient reports right knee pain rated 8/10 related to prior orthopedic procedures and discomfort around the chest/LVAD site. Blood pressure could not be obtained manually, reportedly requiring ultrasound measurement at the provider's office. Oxygen saturation was 99%, and no abnormal lung sounds were noted. The patient denies falls, urinary discomfort, or abnormal bleeding and reports his last bowel movement was the previous night. Medication reconciliation and education were completed, including instruction regarding medication actions, side effects, and anticoagulant-related bleeding precautions; the patient reports metoprolol was discontinued due to a medication interaction. Appetite is fair, and he reports sleeping well with melatonin. PT evaluation revealed decreased strength, gait and functional transfer deficits, and reduced endurance; the patient ambulates approximately 30 feet 2 indoors with supervision and transfers with supervision, while bed mobility is independent. Tinetti score was 17/28, indicating increased fall risk, and the patient is considered homebound due to the significant effort required to leave the home. Skilled PT is recommended to improve strength, balance, gait, transfers, endurance, and overall functional independence. OT evaluation found the patient functioning at his baseline level and independently completing self-care tasks; therefore, no additional skilled OT services are warranted at this time. SN is planned at 2 visits weekly for 2 weeks followed by 1 visit weekly for 6 weeks, with PT services ordered and continued follow-up with cardiology.
<o:p></o:p> Date of Order<o:p></o:p> 09/01/2026<o:p></o:p> Physician Face-to-Face Date: 08/11/2026<o:p></o:p> Clinical Condition Requiring Home Care per Certifying Physician: sn-disease mangement pt-eval & treat ot-eval & treat. dx: Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease<o:p></o:p> Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>   1 - SOC - SN Notes: <o:p></o:p> PT Eval Notes:<o:p></o:p> OT Eval Notes:<o:p></o:p> Physician: LaLonde, Gregory

SN Careplans

SN frequency WK1: 2 (09/01/26-09/05/26) ,WK2: 1 (09/06/26-09/12/26) ,WK4: 1 (09/20/26-09/26/26) ,WK5: 1 (09/27/26-10/03/26) ,WK6: 1 (10/04/26-10/10/26) ,WK7: 1 (10/11/26-10/17/26)

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: 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

SN Goals

PATIENT-STATED GOAL: To improve health and adjust to LVad

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
* 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 self-administers medications as prescribed

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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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.

No open wound noted
Advance Directive:Na

09/02/2026 Problems : abnormal BS < 70/140 > mg/dL (EM)
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
chest pain
abnormal blood pressure
abn cholesterol > 200 mg/dL
daytime fatigue
balance deficit
muscle weakness
limited strength
limited endurance
genital irritation
heartburn/indigestion
loss of appetite
red/tender pressure points
meal preparation
M2102c - Med Admin
D0160 - Depression
M2102f - Patient Supervision
M2102d - Caregiver Performs Treatment

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

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, * 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 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

* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient is adequately supervised

meal preparation is available to patient for all meals

PT Careplans

PT frequency WK1: 1 (09/01/26-09/05/26) ,WK2: 1 (09/06/26-09/12/26) ,WK3: 1 (09/13/26-09/19/26) ,WK4: 1 (09/20/26-09/26/26) ,WK5: 1 (09/27/26-10/03/26) ,WK6: 1 (10/04/26-10/10/26) ,WK7: 1 (10/11/26-10/17/26)

09/08/2026 Problems : GG0170P1 - Picking Up Object
GG0130F1 - Upper Body Dressing
GG0130A1 - Eating
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene

PT Goals

PATIENT-STATED GOAL: To be able to exit the building by myself and not be tired.

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
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GG0170E1 - Chair to Bed to Chair
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170D1 - Sit to Stand
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
GG0170G1 - Car Transfer
GG0170F1 - Toilet Transfer

PROCEDURES: home exercise program: Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumpa, equipment training, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 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, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 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

Picking Up Object - 04. Supervision or touching assistance

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

OT Careplans

OT frequency WK1: 1 (09/02/26-09/05/26)

09/08/2026 Problems : M1400 - Dyspnea

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 - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Evaluation only

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 4 of 4
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