Home Health Certification and Plan of Care

Order ID: 1150/21763

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
33465398	09/01/2026	From: 09/01/2026 To: 10/30/2026	22995	217058

6. Patient's Name and Address
Steven Albright
25 HANFORD DRIVE,
HARMANS, MD 21077-
410-760-5205

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 01/17/1942 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	09/01/26

13. ICD	Other Pertinent Diagnoses	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	09/01/26
I50.33	Acute on chronic diastolic (congestive) heart failure	09/01/26
N18.30	Chronic kidney disease stage 3 unspecified	09/01/26
D63.0	Anemia in neoplastic disease	09/01/26
E11.65	Type 2 diabetes mellitus with hyperglycemia	09/01/26
J96.11	Chronic respiratory failure with hypoxia	09/01/26
I48.91	Unspecified atrial fibrillation	09/01/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	09/01/26
F03.90	Unsp dementia unsp severity without beh/psych/mood/anx	09/01/26
F05.	Delirium due to known physiological condition	09/01/26
E78.5	Hyperlipidemia unspecified	09/01/26
K59.00	Constipation unspecified	09/01/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	09/01/26
Z87.440	Personal history of urinary (tract) infections	09/01/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	09/01/26
Z86.711	Personal history of pulmonary embolism	09/01/26
Z79.4	Long term (current) use of insulin	09/01/26
Z79.01	Long term (current) use of anticoagulants	09/01/26

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

Oxygen - Oxygen 3.5 l nasal cannula continuous supplemental O2
Duoneb - Albuterol Sulfate: Ipratropium Bromide 0.5-2,5 3mg/3ml; take 3 ml inhalant four times a day sob
AMIODARONE 200 mg / tablet by mouth once a day arrythmia
Atorvastatin - Atorvastatin Calcium 80 mg; / 1 tablet by mouth in the evening cholesterol
ELIQUIS 2.5 mg / 1 tablet Oral twice a day PE
Fenofibrate - Fenofibrate 145 mg / 1 tablet by mouth in the evening CHOLESTEROL
FUROSEMIDE 20 mg 20 mg; / 1 TAB by mouth twice a day FLUID PILL
Mucinex - Guaifenesin 600 mg 600MG; 1 TAB by mouth once a day CONGESTION
Insulin Lispro 100 unit/ml / 4 units subcutaneous three times a day before meals
DM
Jardiance - Empagliflozin 25 mg / 1 tablet by mouth once a day DM2
Metoprolol Succinate - Metoprolol Succinate eq 25 mg tartrate 25 mg; 1 TAB by mouth once a day BLOOD PRESSURE
Entresto - Sacubitril: Valsartan 24-26 mg / 1 tablet by mouth twice a day BLOOD PRESSURE
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg/ 1 capsule by mouth once a day BPH
Tresiba - Insulin Degludec 100UNIT/ML; 16 UNITS subcutaneous once a day DM2

14. DME and Supplies:
diabetic supplies, oxygen supplies, walker

15. Safety Measures:
standard precautions, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, walker precautions, O2 precautions, medication safety, transfer with assist, supervision at all times, sharps precautions, anticoagulant precautions, activity supervision

16. Nutrition:
cardiac diet, 2gm sodium, diabetic

17. Allergies:
vancomycin

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Up As Tolerated, Walker, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, 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, 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
family/caregiver will be responsible for managing treatment

Homebound status:
Due to diagnosis of Type 2 diabetes mellitus with diabetic 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
Daniele Johnson
116 Defense Hwy Ste 400
Annapolis, MD 21401
PHONE: 240-744-0001 FAX: 18882060912 NPI: 1487425369

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 : 07/29/2026

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:

The patient is an 84-year-old male with a significant medical history of type 2 diabetes mellitus on insulin, dementia, CHF, CAD status post MI, hyperlipidemia, pulmonary embolism, anemia, atrial fibrillation on Eliquis, chronic left lower-extremity cellulitis, and bilateral lower-extremity lymphedema. He was recently hospitalized due to worsening bilateral lower-extremity lymphedema and redness/cellulitis and subsequently transferred to rehabilitation before returning home approximately one week ago. Furosemide was increased to 20 mg twice daily. The patient is alert and oriented to person and place but is forgetful and demonstrates impaired short-term memory and difficulty recalling the date, month, and year. He is on continuous supplemental oxygen, requiring approximately 3-4 L/min; oxygen saturation was 92% without oxygen and 99% on 4 L/min. Heart rate was 50 bpm and temperature was 97.5F. The patient denies pain and shortness of breath at rest, although his spouse reports shortness of breath with moderate exertion and notes that he requires continued reinforcement to keep his oxygen in place. Bilateral lower-extremity edema of approximately +2 to +3 was noted, with persistent redness, swelling, and reported oozing related to cellulitis. The patient uses a rollator for safe ambulation and has difficulty negotiating the four steps required to enter the home, remaining primarily on the main level. He requires assistance with ADLs/IADLs, including moderate assistance for bathing and assistance with lower-body dressing, while his spouse provides support as needed. Functional assessment revealed decreased bilateral lower-extremity strength, impaired balance, unsteady gait, decreased functional mobility, difficulty with transfers and stair negotiation, decreased safety awareness, and increased fall risk. Additional deficits include impaired short-term memory, proprioception, and stereognosis, with intermittent productive cough. Girth measurements were noted as 12.5 inches at the left foot and 17 inches at the left mid-thigh, and 12 inches at the right foot and 16 inches at the right mid-thigh. Skilled SN services provided medication review, oxygen-safety education, reinforcement of blood glucose monitoring using the patient's Freestyle Libre device, and instruction on meticulous lower-extremity skin care to prevent further skin breakdown. Skilled PT and OT services are indicated to address strength, balance, endurance, gait, transfers, stair negotiation, ADL performance, safety awareness, and overall functional independence. The patient is considered homebound due to cardiopulmonary disease, limited endurance, impaired mobility, increased fall risk, and the significant effort and assistance required to safely leave the home.<o:p></o:p>   Date of Order<o:p></o:p> 09/01/2026<o:p></o:p> Physician Face-to-Face Date: 07/29/2026<o:p></o:p> Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Type 2 diabetes mellitus with diabetic 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: Johnson, Daniele

SN Careplans

SN frequency WK1: 2 (09/01/26-09/05/26) ,WK2: 2 (09/06/26-09/12/26) ,WK3: 1 (09/13/26-09/19/26) ,WK4: 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: 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, 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

SN Goals

PATIENT-STATED GOAL: SPOUSE GOAL IS FOR PATIENT TO STAY AS HEALTHY AS POSSIBLE

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
* 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

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	09/01/2026

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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:POLST (Physician Orders for Life-Sustaining Treatment)

09/08/2026 Problems : #1 - Blister - Anterior Right Below Knee - Open and leaking
M1700 - Cognition
M1720 - Anxiety
M1745 - Behavioral Issues
M1033 - Exhaustion
M1400 - Dyspnea
M2020 - Oral Med Management
lung sounds not clear
dependent edema
balance deficit
limited strength
swelling of affected area
limited endurance
obesity
swell/redness surround. skin
abnormal BS < 70/140 > mg/dL
meal preparation

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, apply compression bandage, glucose testing via monitor, monitor intake & output, coordinate/arrange preparation of missing meals, monitor dialysis schedule

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, * how to keep home safe for patient with dementia coping strategies for the caregiver*, 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, meal preparation is available to patient for all meals

patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* 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

PT Careplans

PT frequency WK1: 1 (09/01/26-09/05/26) ,WK3: 1 (09/13/26-09/19/26) ,WK5: 1 (09/27/26-10/03/26) ,WK7: 1 (10/11/26-10/17/26)

09/04/2026 Problems : 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: train caregiver(s) to perform medical/rehabilitation treatments: Teach PCGs how to administer HEP, home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls.,

PT Goals

PATIENT-STATED GOAL: To be able to safely walk up and down the steps to exit the home

GOALS
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

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

09/01/2026

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equipment training: Walker/cane, dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training/stair training, transfers training, assist with fall prevention: teach falls risk reduction strategies.

TEACH PATIENT/CAREGIVER: 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, 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

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 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)

09/04/2026 Problems : Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
GG0130B1 - Oral Hygiene
GG0130C1 - Toileting Hygiene
GG0130E1 - Shower/Bathe Self
GG0130G1 - Lower Body Dressing
GG0130H1 - Don/Doff Footwear
GG0130A1 - Eating
GG0130F1 - Upper Body Dressing

PROCEDURES: cough/deep breathing exercises, incentive spirometer, home exercise program: Deep breathing strengthening exes for shoulder elbow and wrist, equipment training, work simplification/energy conservation

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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Stated by PCG to be able to do stairs;Stated by PCG to be able to do stairs, to go to second level

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

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