

Home Health Certification and Plan of Care				Order ID: 1150/17345										
1. Patient's HI claim No. 37150220		2. Start Of Care Date 03/17/2026		3. Certification Period From: 03/17/2026 To: 05/15/2026		4. Medical Record No. 23336		5. Provider No. 217058						
6. Patient's Name and Address Ronald Laster 7503 Reserve Circle Apt 101, WINDSOR MILL, MD 21244- 443-750-8908					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 05/27/1944					9. Sex Male					10. Medications: Dose/Frequency/Route (N)ew (C)hanged Silvadene - Silver Sulfadiazine 1 application topical once a day to scalp Metoprolol Tartrate - Metoprolol Tartrate 25 mg 25mg; 1 tab by mouth once a day a -fib ELIQUIS 5 MG by mouth two times a day for DVT Norvasc - Amlodipine Besylate eq 10 mg base 10mg; 1 tab by mouth once a day blood pressure Atorvastatin - Atorvastatin Calcium 40mg; 1 tab by mouth in the evening cholesterol FUROSEMIDE 40 mg 40 MG by mouth one time a day for HTN Potassium Chloride - Potassium Chloride 10meq 10 meq; 2 tabs by mouth once a day supplement				
11. ICD T22.251D		Principal Diagnosis Burn of second degree of right shoulder subs encntr			Date 03/17/26		15. Safety Measures: walker precautions, medication safety, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, supervision at all times, ambulates with assistance, wheelchair precautions, standard precautions, anticoagulant precautions, activity supervision							
13. ICD T22.252D		Other Pertinent Diagnoses Burn of second degree of left shoulder subsequent encounter			Date 03/17/26									
T20.20XD		Burn second degree of head face and neck unsp site subs			03/17/26									
T22.232D		Burn of second degree of left upper arm subs encntr			03/17/26									
T23.202A		Burn of second degree of left hand unsp site init encntr			03/17/26									
E11.9		Type 2 diabetes mellitus without complications			03/17/26									
I10.		Essential (primary) hypertension			03/17/26									
I48.0		Paroxysmal atrial fibrillation			03/17/26									
E78.5		Hyperlipidemia unspecified			03/17/26		17. Allergies: No Known Medication Allergies; Environmental Allergies: Garlic							
Z79.01		Long term (current) use of anticoagulants			03/17/26									
Z87.891		Personal history of nicotine dependence			03/17/26									
14. DME and Supplies: wound care supplies, grab bars, bath bench, walker, wheelchair					16. Nutrition: diabetic					17. B. Activities Permitted Wheelchair, Up As Tolerated, Walker,				
19. Mental & Psychosocial 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: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No					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 family/caregiver will be responsible for managing treatment					Homebound status: Due to diagnosis of Burn of second degree of right shoulder, subsequent encounter, 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: <p class="MsoNoSpacing">The patient is a 81-year-old male admitted to home health services for skilled nursing and physical/occupational therapy evaluation following hospitalization and subacute rehabilitation for burn injuries sustained in a house fire, involving approximately 11.5% of the body (face, shoulders, left arm, hands), with a history of IV fluid and albumin treatment and new-onset atrial fibrillation. His past medical history includes type 2 diabetes mellitus, hypertension, hyperlipidemia, chronic pain, debility, gait abnormality, frailty, endocarditis, and bacteremia. The patient is alert and oriented 3, denies significant pain but reports intermittent scalp itching and occasional cough, with stable appetite and no shortness of breath; lungs are clear, and all burn and graft sites are healed, with residual scabbing to the scalp managed with topical treatment. He requires assistance with activities of daily living and instrumental activities, with family support, and declines home health aide services. Functionally, he demonstrates decreased strength and endurance, requiring contact guard assistance for transfers and short-distance ambulation with a rolling walker, along with verbal cues for posture; however, he is modified independent at the wheelchair level for self-care tasks. Skilled nursing focused on medication and skin care education has been provided, and continued physical therapy is recommended to improve strength, balance, safety, and functional mobility, while no further skilled occupational therapy services are indicated at this time. <o:p></o:p></p> <p class="MsoNoSpacing"><o:p></o:p></p> <p class="MsoNoSpacing"><o:p></o:p></p> <p class="MsoNoSpacing">Date of Order<o:p></o:p></p> <p class="MsoNoSpacing">03/17/2026 Order<o:p></o:p></p> <p class="MsoNoSpacing">Physician Face-to-Face Date: 02/02/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease & medication management PT-eval & treat OT-eval & treat DX: Burn of second degree of right shoulder, subsequent encounter 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></p> <p class="MsoNoSpacing"> 1 - SOC -SN Notes:<o:p></o:p></p> <p class="MsoNoSpacing">PT Eval Notes: OT Eval Notes:<o:p></o:p></p> <p class="MsoNoSpacing">Physician:Tansinda, James</p>				
SN Careplans					SN Goals									
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 03/17/2026					25. Date HHA Received Signed POT									
24. Physician's Name and Address James Tansinda 726 Maiden Choice Catonsville, MD 21228 PHONE: 4107441101 FAX: 14107441186 NPI: 1184690141					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 : 02/02/2026									
27. Attending Physician's Signature and Date Signed 04/08/2026 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. PAGE 1 of 3									

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SN WK1: 1 (03/17/26-03/21/26) ,WK2: 1 (03/22/26-03/28/26) ,WK3: 2 (03/29/26-04/04/26) ,WK4: 1 (04/05/26-04/11/26) ,WK5: 1 (04/12/26-04/18/26) 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, 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 PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, coughing, limited strength, limited endurance, balance deficit, discolored patches of skin, itchy skin, #1 - Burn - Other - SCALP - SCABBED PROCEDURES: physician-ordered wound care: #1 - Burn - Other - SCALP - SCABBED: APPLY SILVADENE DAILY, Pain management: Assess pain level at each visit, document description and location of pain, medication review: Review medications each visit, Report Missing, New, Changed, Discontinued medications, 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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-STATED GOAL: TO GET BETTER 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 * 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 * 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 meal preparation is available to patient for all meals		
PT Careplans PT WK1: 1 (03/17/26-03/21/26) ,WK2: 1 (03/22/26-03/28/26) ,WK3: 1 (03/29/26-04/04/26) ,WK4: 1 (04/05/26-04/11/26) ,WK5: 1 (04/12/26-04/18/26) ,WK6: 1 (04/19/26-04/25/26) ,WK7: 1 (04/26/26-05/02/26) ,WK8: 1 (05/03/26-05/09/26) PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170R1 - Wheel 50 ft w 2 Turns, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170S1 - Wheel 150 feet PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, cough/deep breathing exercises, gait training/stair training, transfers training		PT Goals PATIENT-STATED GOAL: To be able to walk again GOALS 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		
Signature of Physician:		Date PAGE 2 of 3		
Optional Name/Signature of Nurse/Therapist: Electronically Signed by Messick, Charles RN		Date 03/17/2026		

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TEACH PATIENT/CAREGIVER: * 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, 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			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 (03/17/26-03/21/26) PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating 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, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, 1 - Step (curb) - 02. Substantial/maximal assistance, 12 Steps - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Car Transfer - 05. Setup or clean-up assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent			OT Goals PATIENT-STATED GOAL: OT eval only 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 Wheel 50 ft w 2 Turns - 06. Independent Wheel 150 feet - 06. Independent 1 - Step (curb) - 02. Substantial/maximal assistance 12 Steps - 02. Substantial/maximal assistance 4 Steps - 02. Substantial/maximal assistance Car Transfer - 05. Setup or clean-up assistance Picking Up Object - 02. Substantial/maximal assistance Walk 10 Feet - 02. Substantial/maximal assistance Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance Walk 150 Feet - 02. Substantial/maximal assistance Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Shower/Bathe Self - 04. Supervision or touching assistance Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent			

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