Home Health Certification and Plan of Care

Order ID: 1150/20993

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
7D61DM9MA15	07/31/2026	From: 07/31/2026 To: 09/28/2026	28646	217058

6. Patient's Name and Address

Steven Craig
308 Willrich Cir Unit B,
FOREST HILL, MD 21050-
410-688-1502

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 03/04/1949 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z48.812	Encntr for surgical aftcr following surgery on the circ sys	07/31/26

13. ICD	Other Pertinent Diagnoses	Date
Z95.1	Presence of aortocoronary bypass graft	07/31/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	07/31/26
I10.	Essential (primary) hypertension	07/31/26
E78.5	Hyperlipidemia unspecified	07/31/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	07/31/26
I48.0	Paroxysmal atrial fibrillation	07/31/26
E11.65	Type 2 diabetes mellitus with hyperglycemia	07/31/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	07/31/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/31/26
K22.70	Barrett's esophagus without dysplasia	07/31/26
I25.2	Old myocardial infarction	07/31/26
Z85.820	Personal history of malignant melanoma of skin	07/31/26
Z87.891	Personal history of nicotine dependence	07/31/26
Z79.82	Long term (current) use of aspirin	07/31/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	07/31/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	07/31/26
Z79.01	Long term (current) use of anticoagulants	07/31/26
Z79.4	Long term (current) use of insulin	07/31/26
Z79.891	Long term (current) use of opiate analgesic	07/31/26
Z95.5	Presence of coronary angioplasty implant and graft	07/31/26
Z95.828	Presence of other vascular implants and grafts	07/31/26

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

(GLUCOSAMINE-CHONDROITIN) TABS L-LYSINE - by mouth once a day
CHROMIUM PICOLINATE - by mouth daily.
Vitamin E - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox - by mouth daily.
Vitamin D-3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox - by mouth daily.
Vitamin C - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox - by mouth daily.
Vitamin B-12 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox - by mouth daily.
Vitamin B Complex - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 0 Take 1 tablet by mouth daily.
Vitamin A - Vitamin A Palmitate - by mouth daily.
turmeric - by mouth daily.
PLAVIX 75 MG tablet by mouth daily.
PROSCAR 5 MG tablet by mouth .daily.
PROTONIX Delayed Release 40 MG tablet by mouth 1 time daily as needed.
probiotics - by mouth daily.
MULTIVITAMIN 0 Take 1 tablet by mouth daily.
Menaquinone-7 (VITAMIN K2 PO) - by mouth once a day
Methylsulfonylmethane (MSM PO) - by mouth daily.
ASPIRIN 0 Chewable 81 MG tablet by mouth daily.
MAGNESIUM - by mouth daily.
LIPITOR 80 MG tablet by mouth every evening.
GLUCOPHAGE 500 MG tablet by mouth twice a day as needed (will take in place of 850mg tablet if BS is low).
Alpha-lipoic acid (ALA) - by mouth daily.
Amiodarone - Amiodarone Hydrochloride 200 MG tablet Take 1 tablet by mouth twice a day take one tablet by mouth, 2 times daily for 5 days, then 1 tablet daily.
Farxiga - Dapagliflozin Propanediol 5mg, 1 tablet by mouth once a day
Farxiga - Dapagliflozin Propanediol 5mg, 1 tablet by mouth once a day
Furosemide - Furosemide 40 mg take 1 tablet by mouth once a day X 10days
Toprol-Xl - Metoprolol Succinate 50mg, take 1 tablet by mouth once a day
Potassium Chloride - Potassium Chloride 20meq take 1 tablet by mouth once a day X 10 DAYS
Miralax - Polyethylene Glycol 3350 17gm/scoopful 1 packet by mouth once a day stir and dissolve 1 packet in any 4-8 ounces of non-carbonated beverage.
Magnesium Citrate - Magnesium Citrate 1.745gm/30ml by mouth once a day 1 dose only
Glucophage - Metformin Hydrochloride 500 mg 1 tablet by mouth twice a day
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, 1 tablet by mouth every 6 hours as needed for pain

14. DME and Supplies:

diabetic supplies, bath bench, walker

15. Safety Measures:

standard precautions, bleeding precautions, fall precautions, diabetic precautions, ambulates with device, walker precautions, medication safety, bathroom safety, anticoagulant precautions

16. Nutrition:

cardiac diet

17. Allergies:

sulfa drugs

18.A. Functional Limitations

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: 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

patient will be responsible for managing treatment

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/31/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Yuvraj Kamboj
2014 S Tollgate Rd
Bel Air, MD 21015
PHONE: 4106709200 FAX: 14106709201 NPI: 1528237930

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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6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Steven Craig 308 Willrich Cir Unit B, FOREST HILL, MD 21050- 410-688-1502	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Homebound status: After undergoing Coronary artery bypass grafting (CABG) 3 utilizing the left internal mammary artery (lima) and saphenous vein graft harvesting, 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 77-year-old male admitted to skilled home health services following hospitalization for worsening chest pain of three weeks' duration. His past medical history is significant for essential hypertension, hyperlipidemia, diabetes mellitus, peripheral artery disease with prior left superficial femoral artery (SFA) atherectomy and stent placement in 2021, and gastroesophageal reflux disease (GERD) with a history of Barrett's esophagitis. Following cardiology evaluation, the patient underwent coronary artery bypass grafting (CABG) 3 utilizing the left internal mammary artery (LIMA) and saphenous vein graft harvesting. The patient is alert and oriented 4, with normal heart sounds noted on assessment. Surgical incisions to the chest and leg were assessed and found to be stable, clean, dry, intact, and left open to air without redness, swelling, drainage, or other signs and symptoms of infection. Assessment revealed +2 bilateral lower extremity edema, and the patient was instructed to elevate his legs while sitting to assist with edema management. The patient denied shortness of breath and demonstrated compliance with postoperative pulmonary hygiene by splinting with his cardiac pillow while coughing and using the incentive spirometer 10 times daily as prescribed. Discharge instructions were thoroughly reviewed with the patient and his wife, including adherence to a low-sodium cardiac diet, daily showering with gentle cleansing of surgical incisions using mild soap and water followed by patting the areas dry without rubbing, daily weight monitoring, and notifying the physician for a weight gain greater than 5 pounds within 24 hours or a temperature exceeding 100.5F. The patient reported constipation upon the nurse's arrival and had already taken laxatives. Bowel sounds were active in all quadrants, and the patient was able to have a bowel movement by the end of the visit. The patient ambulates slowly with a walker throughout his condominium and requires assistance with some activities of daily living due to decreased endurance and postoperative weakness. He resides with his wife, who serves as his primary caregiver, while his daughter is available to provide additional assistance as needed. Skilled nursing services remain medically necessary for ongoing cardiopulmonary assessment, postoperative incision monitoring, edema management, medication management and education, reinforcement of cardiac precautions and disease management, monitoring for postoperative complications, and continued patient and caregiver education to promote optimal recovery, prevent complications, and reduce the risk of rehospitalization.
 Date of Order 07/31/2026 Orders Physician Face-to-Face Date: 07/29/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease process due to Coronary artery bypass grafting (CABG) 3 utilizing the left internal mammary artery (lima) and saphenous vein graft harvesting 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 Kamboj, Yuvraj

SN Careplans

SN WK1: 1 (07/31/26-08/01/26) ,WK2: 1 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (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:Refused

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, coughing, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, limited strength, balance deficit, Pain Interference with ADLs, loss of appetite, swell/redness surround. skin, #1 -

SN Goals

PATIENT-STATED GOAL: To heal properly without getting any infections.

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
* 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
* 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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/31/2026

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Observable Surgical Wound - Anterior Midline - Mid chest surgical site, #2 - Observable Surgical Wound - Anterior Midline - lower mid chest surgical incision, #3 - Observable Surgical Wound - Anterior Left Abdomen - left upper abdomen surgical incision 1, #4 - Observable Surgical Wound - Anterior Left Abdomen - left upper abdomen surgical incision 2, #5 - Observable Surgical Wound - Anterior Right Foot -

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Midline - Mid chest surgical site: leave open to air, physician-ordered wound care: #2 - Observable Surgical Wound - Anterior Midline - lower mid chest surgical incision: leave open to air, physician-ordered wound care: #3 - Observable Surgical Wound - Anterior Left Abdomen - left upper abdomen surgical incision 1: leave open to air, physician-ordered wound care: #4 - Observable Surgical Wound - Anterior Left Abdomen - left upper abdomen surgical incision 2: leave open to air, physician-ordered wound care: #5 - Observable Surgical Wound - Anterior Right Foot -: leave open to air, cough/deep breathing exercises, incentive spirometer, glucose testing via monitor

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, * 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

Signature of Physician:	Date
	PAGE 3 of 3
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