HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022145

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
411051180	09/16/2026	09/16/2026 - 11/14/2026	30248	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Carlos Umana 5413 Clifton Avenue GWYNN OAK, MD 21207	Male	06/07/1945	301-875-1171
	Email		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI 1487113239		**Fax Number** 410-559-3002

Clinical Condition Requiring Homecare:

The patient is an 81-year-old male with a medical history significant for dementia with bilateral mild nonproliferative diabetic retinopathy, hypertension, type 2 diabetes mellitus, BPH with urinary retention, anemia, glaucoma, hypothyroidism, and recently diagnosed pituitary adenoma. He was recently hospitalized and subsequently discharged from subacute rehabilitation due to generalized weakness, confusion, and dementia. The patient is alert and oriented 2 with noted confusion. He is currently primarily wheelchair-dependent and requires human assistance when leaving the home due to impaired mobility and increased risk for falls, supporting homebound status. Prior to hospitalization, he was ambulating with a single-point cane and supervision; currently, he demonstrates decreased lower-extremity strength (3-/5 MMT), requires moderate assistance for sit-to-stand transfers, and requires minimal to contact-guard/standby assistance for functional ambulation and transfers using a rolling walker, with verbal cues for improved trunk extension. He requires maximal assistance/dependence for bathing, dressing, and toileting tasks. Bilateral upper-extremity strength is 4/5. Skin is warm, dry, and intact; lung sounds are clear bilaterally, respirations are even and unlabored, and no complaints were voiced. The patient would benefit from skilled PT services to improve strength, balance, functional mobility, safety, and independence and to facilitate return toward his prior level of function.<o:p></o:p>

Date of Order<o:p></o:p>
09/16/2026<o:p></o:p>
Physician Face-to-Face Date:
09/03/2026<o:p></o:p>
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Type 2 diabetes mellitus with diabetic polyneuropathy<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>

Physician Statement on Homebound Status:

Due to diagnosis of Type 2 diabetes mellitus with diabetic polyneuropathy, unspecified, 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

1 - SOC - SN Notes: <o:p></o:p>
PT Eval Notes:<o:p></o:p>
OT Eval Notes:<o:p></o:p>
Physician: Dicocco, Eva

ICD-10 CM Principal Diagnosis: E11.42. Type 2 diabetes mellitus with diabetic polyneuropathy

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
E03.9	Hypothyroidism unspecified	ACETAMINOPHEN 325 MG mouth every 6 hours as needed for pain ATORVASTATIN 20 MG mouth in the evening for HLD DONEPEZIL HYDROCHLORIDE 5 MG mouth in the morning for Dementia DORZOLAMIDE HYDROCHLORIDE 2-0.5 % both eyes every 12 hours for HTN LATANOPROST 0.005 % both eyes in the evening for HTN LEVOTHYROXINE 50 MCG mouth in the morning for Hypothyroidism Before breakfast METFORMIN 1000 MG mouth two times a day for DM2 POLYETHYLENE GLYCOL 17 GM mouth one time a day for Constipation 4-8 oz non carbonated beverage
F02.80	Dem in oth dis classd elswhrunsp sevw/o beh/psych/mood/anx	
I10.	Essential (primary) hypertension	
H40.9	Unspecified glaucoma	
D35.2	Benign neoplasm of pituitary gland	
D63.8	Anemia in other chronic diseases classified elsewhere	
N40.1	Benign prostatic hyperplasia with lower urinary tract symp	
R33.8	Other retention of urine	
E44.0	Moderate protein-calorie malnutrition	
F10.90	Alcohol use unspecified uncomplicated	
H04.129	Dry eye syndrome of unspecified lacrimal gland	
Z79.4	Long term (current) use of insulin	
Z79.890	Hormone replacement therapy	
Z79.84	Long term (current) use of oral hypoglycemic drugs	

Prognosis
fair

Mental and Psychosocial 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

Functional Limitations
Endurance, Bowel/Bladder Incontinence, Ambulation

Activities Permitted
Transfer bed/Chair, Wheelchair, Walker, Exercises Prescribed, Up As Tolerated

DME & Supplies
diabetic supplies, walker, wheelchair

Safety Measures
smoke detectors , emergency phone # clearly displayed, bedrails up while in bed, activity supervision, bathroom safety, hand rails, medication safety, supervision at all times, transfer with assist, diabetic precautions, fall precautions, standard precautions, wheelchair precautions, walker precautions, ambulates with device, ambulates with assistance

Nutrition
diabetic, cardiac diet

Allergies
no known allergies

Advance Directives	Caregiver Status
Yes	2. Non-agency caregiver(s) need training/supportive services to provide assistance; 2. Non-agency caregiver(s) need training/supportive services to provide assistance
Rehabilitation Potential	**DISCHARGE PLAN:**
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.	SN: family/caregiver will be responsible for managing treatment PT and OT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - SN

OT Eval

PT Eval

SN CAREPLAN

SN frequency WK1: 1 (09/16/26-09/19/26),WK2: 2 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK6: 1 (10/18/26-10/24/26),WK8: 1 (11/01/26-11/07/26)

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: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 3. Multiple hospitalizations (2

or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 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

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:Yes

SN NARRATIVE

Patient is homebound status due to Dementia withbilateral mild nonproliferative retinopath, HTN, DM2 leaving the home patient is at increase risk for falls. Patient use wheelchair at this time and requires human assistance when leaving the home for safety.Patient alert and orient x2- with confusion. Skin dry,warm and intact.Lung sounds clear. Respiration even and unlabored.No complaints voiced.

Patient is has Dementia withbilateral mild nonproliferative retinopath, HTN, DM2 leaving the home patient is at increase risk for falls. Patient use wheelchair at this time and requires human assistance when leaving the home for safety.Patient alert and orient x2- with confusion. Skin dry,warm and intact.Lung sounds clear. Respiration even and unlabored.No complaints voiced.

SN GOALS

PATIENT-STATED GOAL: Caregiver states they want patient to regain some strength

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 keep home safe for patient with dementia
* coping strategies for the caregiver* 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

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

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

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

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training

09/17/2026 Problems : limited strength (MS)
limited endurance (MS)
urine retention (GU)
frequent urination (GU)
loss of appetite (NU)
M1720 - Anxiety
M1745 - Behavioral Issues
M1033 - Exhaustion
M1400 - Dyspnea
M2020 - Oral Med Management
delayed capillary refill
withdrawal from conversations
muscle weakness
B1000 - Vision Deficit
M1700 - Cognition
M2102d - Caregiver Performs Treatment
M2102f - Patient Supervision
M1610 - Urinary Incontinence
M1620 - Bowel Incontinence
M1033 - Unintentional Weight Loss
M2102c - Med Admin

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, monitor intake & output, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange resources for vision-impaired

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 increase caloric intake, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin 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, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

OT CAREPLAN
OT frequency WK2: 1 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26),WK6: 1 (10/18/26-10/24/26),WK7: 1 (10/25/26-10/31/26)

09/21/2026 Problems : M1400
GG0130B1 - Oral Hygiene
GG0130C1 - Toileting Hygiene
GG0130E1 - Shower/Bathe Self
GG0130F1 - Upper Body Dressing
GG0130G1 - Lower Body Dressing
GG0130H1 - Don/Doff Footwear
GG0130A1 - Eating

PROCEDURES: Therapeutic exercises : Using dumbbells or therabands to perform bilateral upper extremity muscle strength exercises, Transfer training: Sit to stand transfers, Patient/caregiver recalls related purpose and schedule of medications: Medication Review, 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, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 01. Dependent, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 03. Partial/moderate assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 03. Partial/moderate assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent, Patient will demonstrates improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve Adls and transfers safely

OT NARRATIVE
Patient is a 81 year old man who was recently discharged from subacute rehab secondary to generalized weakness, confusion, and dementia. He was recently dx with Pituitary adenoma. He has a past medical history of DM2, BPH with urinary retention, dementia, anemia, htn, glaucoma and hypothyroidism. Patient lives with his family in a house. He is max assistance/dependent for bathing, dressing and tolieting task. Patient is moderate assistance for sit to stand transfers. He demonstrates weakness of 4/5 mmt of bilateral upper extremity muscle strength. Patient is standby/contact guard assistance for functional ambulation using his rolling walker

OT GOALS
PATIENT-STATED GOAL: Family wants patient to get stronger

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

Sit to Stand - 05. Setup or clean-up assistance

Toilet Transfer - 01. Dependent

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 03. Partial/moderate assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 03. Partial/moderate assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

	Eating - 06. Independent Patient will demonstrates improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve Adls and transfers safely

PT CAREPLAN
PT frequency WK2: 1 (09/20/26-09/26/26),WK4: 1 (10/04/26-10/10/26),WK6: 1 (10/18/26-10/24/26),WK8: 1 (11/01/26-11/07/26)

09/22/2026 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: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed. Upgrade as tolerated, gait training/stair training, transfers training

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 - 03. Partial/moderate 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

PT NARRATIVE
PT eval completed. Pt is a 81 y.o. male with PMH significant for dementia with bilateral mild nonproliferative retinopath, HTN, DM who was recently hospitalized due to dementia. Prior to hospitalization, pt had been ambulating with SPC and supervision but was living alone. At this time, pt presents with decreased strength with 3-/5 MMT in BLE and requires minA for transfers and short distance ambulation with RW, with vcs to increase trunk ext. Pt would benefit from skilled PT services to increase strength, improve balance and increase safety and independence in functional mobility in order to return to PLOF.

PT GOALS
PATIENT-STATED GOAL: To be able to walk without help

GOALS
Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 03. Partial/moderate 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

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/16/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.
F2F date: 09/03/2026

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.

Certifying Physician or Allowed Practitioner Name and Address **Eva Dicocco**
7141 Security Blvd
Woodlawn, MD 21244
NPI 1598990624

Phone Number 443-663-6000

Fax Number 14436636215

Physician's Signature and Date Signed

X

Eva Dicocco
09/03/2026: Date of physician last face-to-face