

Home Health Certification and Plan of Care				Order ID: 1150/13030
1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
47311041	10/07/2025	From: 10/07/2025 To: 12/05/2025	18216	217058
6. Patient's Name and Address Michael Martel 907 Gladway Rd, MIDDLE RIVER, MD 21220- 410-599-3077			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	10/11/1960	9. Sex	Male	10. Medications: Dose/Frequency/Route (N)ew (C)hanged
11. ICD	Principal Diagnosis	Date	Ibuprofen - Ibuprofen 400 MG, Give 1 tablet by mouth every 8 hours Give 1 tablet by mouth every 8 hours as needed for pain 6-10 Albuterol Sulfate And Ipratropium Bromide - Albuterol Sulfate: Ipratropium Bromide take 0.5-2.5, inhale inhalant in the morning inhale orally in the morning for SOB or Wheezing via nebulizer Mylanta - Simethicone 400-400-40 MGV5ML, Give 30 ml by mouth every 12 hours Give 30 ml by mouth every 012 hours as needed for upset stomach Polyethylene Glycol - Polyethylene Glycol 3350: Potassium Chloride: Sodium Bicarbonate: Sodium Chloride Give 17-gram, powder by mouth once a day Give 17 gram by mouth one time a day for hold for lose stool Gabapentin - Gabapentin 600 mg 600 by mouth four times a day Sometimes I take 2x a day and other times 3x a day depending on pain lev One A Day Vitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpantenol: Folic Acid: Niacinamide: Pyridox 60 tablets by mouth once a day Daily supplement Amlodipine - Amlodipine Besylate 5 MG, Give 1 tablet by mouth once a day Tablet 5 MG Give 1 tablet by mouth one time a day for HTN Hold for SBP lower than 100mmHg and notify MD Artificial Tears - Normal Saline Instill 1 drop in both eyes both eyes three times a day Instill 1 drop in both eyes three times a day for Dry eyes for 7 Days. 1-2 drops in right eyes as needed Acetaminophen - Acetaminophen 500 MG, Give 2 tablet by mouth every 6 hours Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for Pain 1-5 *Use caution wV APAP total daily dose greater than 3,000mg* Melatonin - Melatonin 3 MG Give 1 tablet by mouth as necessary Give 1 tablet by mouth every 24 hours as needed for insomnia to be administered at bedtime Eliquis - Apixaban 5 MG, Give 1 tablet by mouth twice a day Give 1 tablet by mouth two times a day for Afib Protonix - Pantoprazole Sodium eq 40 mg base 40 MG Give 1 tablet by mouth once a day Give 1 tablet by mouth one time a day for GERD Dulcolax - Bisacodyl 354ml by mouth as necessary As needed for constipation Methadone - Methadone Hydrochloride Give 105 mg by mouth once a day Give 105 mg by mouth one time a day for Opioid dependence	
G93.41	Metabolic encephalopathy	10/07/25		
13. ICD	Other Pertinent Diagnoses	Date		
M16.0	Bilateral primary osteoarthritis of hip	10/07/25		
M25.512	Pain in left shoulder	10/07/25		
I89.0	Lymphedema not elsewhere classified	10/07/25		
I10.	Essential (primary) hypertension	10/07/25		
I82.421	Acute embolism and thrombosis of right iliac vein	10/07/25		
K21.9	Gastro-esophageal reflux disease without esophagitis	10/07/25		
E44.0	Moderate protein-calorie malnutrition	10/07/25		
F17.200	Nicotine dependence unspecified uncomplicated	10/07/25		
F11.10	Opioid abuse uncomplicated	10/07/25		
K59.00	Constipation unspecified	10/07/25		
Z79.01	Long term (current) use of anticoagulants	10/07/25		
14. DME and Supplies: nebulizer, commode, hospital bed, 4 wheeled walker				15. Safety Measures: walker precautions, smoke detectors , restricted ROM, , , ambulates with device, hip precautions, remove environmental barriers, ambulates with assistance, , bathroom safety, , activity supervision
16. Nutrition: regular				17. Allergies: no known allergies
18.A. Functional Limitations Endurance, Ambulation				18.B. Activities Permitted Walker, Up As Tolerated
19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 1. Rarely, 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 family/caregiver will be responsible for managing treatment	
Homebound status: Due to diagnosis of Metabolic Encephalopathy , 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 SN RN on 10/07/2025		25. Date HHA Received Signed POT
24. Physician's Name and Address Leopoldine Modjo Kenmogne 3001 Hospital Dr Cheverly, MD 20785 PHONE: 410-737-5000 FAX: 14107375401 NPI: 1114312444		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 : 10/03/2025
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. PAGE 1 of 3

Clinical Condition <div>The patient is a 65-year-old male with a significant past medical history of metabolic encephalopathy, osteoarthritis with Requiring Homecare:ankylosed hips and knees, hypertension, and a prior pneumothorax. He is alert and oriented 3 and remains homebound due to chronic generalized weakness and persistent pain secondary to osteoarthritis. The patient resides with his sister and her husband, who provide intermittent assistance as needed. He ambulates with a walker and uses a hospital bed on the first level of the home for easier access and safety. The patient reports chronic bilateral hip and leg pain rated 7-8/10, which interferes with sleep and daily activities. He currently takes acetaminophen, methadone, and gabapentin, though he reports these provide only partial relief. He has an upcoming primary care appointment to review his pain management plan and discuss potential medication adjustments. His long-term goal is to improve strength and mobility through continued physical therapy, aiming to progress from a walker to a cane or, ideally, to ambulate independently. Physical assessment revealed bilateral hamstring and calf muscle tightness with limited range of motion in both knees and hips. The patient ambulates with a walker, demonstrating an absent heel strike and requiring assistance for safe transfers. Physical therapy focused on lower extremity strengthening and mobility, including long arc quadriceps and straight leg raise exercises, as well as passive stretching and joint mobilization performed by the therapist. The patient's medication regimen was reviewed; he and his sister jointly organize medications in a weekly pillbox. The patient expressed uncertainty about proper timing and conditions for taking or withholding certain medications, particularly antihypertensives. Nursing education on medication management and blood pressure medication use was reinforced, with encouragement for ongoing teaching and monitoring. The patient also reported a previously sustained wound on his right shin that has completely healed. There are no current wound orders, and a photo of the healed area has been uploaded to his chart. Education was provided regarding ongoing skin care and injury prevention. The patient and his caregiver demonstrated understanding of the instructions and expressed commitment to the therapeutic and medication plans. Continue skilled nursing and physical therapy to address pain control, improve joint mobility, enhance strength, and reinforce medication management education. The patient will follow up with his primary care provider regarding pain control and antihypertensive regimen adjustments.</div><div></div><div>
<div><div>Date of Order</div><div>10/07/2025</div><div>Orders</div><div>Physician Face-to-Face Date: 10/03/2025</div><div>Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management PT-eval & treat OT-eval & treat HHA-addls due to Metabolic Encephalopathy</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div></div><div>
</div><div>SOC - SN Notes: soc</div><div>PT Eval Notes:</div><div>Modjo Kenmogne, Leopoldine</div></div></div>

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	10/07/2025

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fluid and diet intake to promote healing prevent constipation home safety, 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, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence	* position changes * skin care * diet modification * record wound measurements * 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 self-administers medications as prescribed * recalls related medication(s) purpose, schedule - patient is adequately supervised - caregiver administers and/or packages medications appropriately - caregiver performs medical/rehabilitation treatments with adequate competence - patient/caregiver recalls * lifestyle modifications to manage cardiac condition including symptom management * diet changes * regular exercise * getting enough sleep * recalls related medication(s) purpose, schedule - patient/caregiver recalls * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings * physical exercise plan * diet * recalls related medication(s) purpose, schedule
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PT Careplans PT WK1: 1 (10/07/25-10/11/25) ,WK2: 2 (10/12/25-10/18/25) ,WK3: 2 (10/19/25-10/25/25) ,WK4: 2 (10/26/25-11/01/25) ,WK5: 1 (11/02/25-11/08/25) ,WK6: 1 (11/09/25-11/15/25) ,WK7: 1 (11/16/25-11/22/25) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object PROCEDURES: Medication Review: The medication was reviewed with the patient , Home exercises: LONG ARC , SLR, LE ABD/ADD, --10X2 REPS , cough/deep breathing exercises, gait training on uneven surfaces, gait training/stair training, transfers training 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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 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	PT Goals PATIENT-STATED GOAL: The patient wants to walk normal GOALS Chair to Bed to Chair - 06. Independent 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 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 - 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 Walk 10 ft on Uneven Surface - 04. Supervision or touching 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
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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