Home Health Certification and Plan of Care

Order ID: 1150/13322

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
83335997	10/21/2025	From: 10/21/2025 To: 12/18/2025	18628	217058

6. Patient's Name and Address
Edward Quince
907 N Central Avenue,
Baltimore, MD 21202-
410-702-8706

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 07/25/1962 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.89	Encounter for other orthopedic aftercare	10/21/25

13. ICD	Other Pertinent Diagnoses	Date
M47.812	Spondylosis w/o myelopathy or radiculopathy cervical region	10/21/25
M48.02	Spinal stenosis cervical region	10/21/25
J45.909	Unspecified asthma uncomplicated	10/21/25
H57.02	Anisocoria	10/21/25
Z79.51	Long term (current) use of inhaled steroids	10/21/25

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

Lidocaine - Lidocaine 2 Patch topical once a day
Montelukast Sodium - Montelukast Sodium 10 Mg , Tablet by mouth at bedtime
Spiriva - Tiotropium Bromide Monohydrate 2 Puff inhalant once a day RT(8A)
Methocarbamol - Methocarbamol 750 Mg Tablet by mouth three times a day Muscle relaxer
Gabapentin - Gabapentin 600 mg 600 Mg, Tablet by mouth three times a day 3x daily for nerve pain
Dulcolax - Bisacodyl 100 by mouth in the morning Stool softner
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth in the morning Taken as needed for
Arnuity Ellipta - Fluticasone Furoate 1 Puff ,Inhalation inhalant once a day
Spray in each nose for congestion
Atorvastatin - Atorvastatin Calcium 10 Mg, Tablet by mouth at bedtime Cholesterol mgt
Acetaminophen - Acetaminophen 650 Mg , Tablet by mouth every 6 hours Taken as needed for pain
Polyethylene Glycol - Polyethylene Glycol 3350: Potassium Chloride: Sodium Bicarbonate: Sodium Chloride 17 G, Tablet by mouth once a day Taken as needed for SOB

14. DME and Supplies:
walker

15. Safety Measures:
ambulates with assistance,

16. Nutrition:
regular

17. Allergies:
no known allergies

18.A. Functional Limitations
Dyspnea With Minimal Exertion, Ambulation, Endurance

18.B. Activities Permitted
Independent at Home, Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., 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: good

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

Homebound status: Due to diagnosis of Encounter For Other Orthopedic Aftercare, 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 63-year-old male who is alert and oriented times four, recently discharged from Johns Hopkins Hospital on October 16 following hospitalization and cervical spine fusion for spinal stenosis and spondylosis with associated myelopathy. The patient reported that the initial episode leading to hospitalization occurred when he suddenly experienced numbness from the neck down while walking to a nearby store, necessitating emergency transport by ambulance. His past medical history is significant for asthma, chronic lower back pain, neuromuscular disorder, obstructive sleep apnea, and hyperlipidemia. Numbness in the upper and lower extremities reportedly began in June 2025 and has persisted postoperatively, though with some improvement. On examination, the patient's surgical incision is located on the posterior neck, with the dressing remaining clean, dry, and intact. Per discharge instructions, the dressing may be removed after five days and left open to air; however, the patient prefers to keep it in place until his follow-up appointment on October 24 for added comfort. He was re-educated on signs and symptoms of infection-including redness, swelling, drainage, increased pain, or fever-and verbalized full understanding. The patient reports moderate postoperative pain rated at 5/10, which he manages primarily with Tylenol and occasionally with oxycodone as needed. He appeared in no acute distress during the visit but endorsed mild shortness of breath with exertion and lightheadedness when standing for prolonged periods. He was advised to rest as needed, avoid overexertion, and report any worsening symptoms, which he understood and agreed to follow. The patient resides alone in a multi-level home with two steps to enter and approximately fifteen stairs to access the bedroom and bathroom. His daughter serves as his primary caregiver, assisting with transportation and heavier tasks. Functionally, the patient ambulates indoors up to 30 feet twice without an assistive device and with supervision. He is able to ascend and descend 14 steps using a handrail with supervision. Bed mobility is performed with verbal cues to maintain spinal precautions, and he transfers safely to and from the bed, chair, and sofa with supervision. The patient demonstrates a posteriorly tilted resting posture that promotes neck flexion; therefore, he was educated on maintaining an upright seated position and advised to use only one pillow at bedtime to support proper spinal alignment. Therapeutic exercises were performed and well tolerated, including supine hip flexion, bridging, and straight leg raises; standing knee flexion, hip abduction, hip extension, plantar flexion, and squats; as well as seated knee extensions and ankle pumps. The patient's limited cervical range of motion is attributed to postoperative pain and use of the cervical collar, which he wears most of the time. A Tinetti score of 19/28 indicates moderate fall risk and supports the medical necessity for home therapy to improve mobility, posture, strength, and independence in daily activities. The therapist noted that the patient may benefit from the use of a hard cervical collar to maintain appropriate neck alignment during recovery. Overall, the patient is progressing postoperatively with stable vital signs and adequate pain control. Continued skilled home physical therapy is recommended to enhance mobility, strength, and endurance while reinforcing spinal precautions and posture training. Ongoing education and monitoring will focus on fall prevention, infection awareness, and adherence to the prescribed plan of care to promote safe return to prior level of function.
 Date of Order 10/21/2025 Orders Physician Face-to-Face Date: 10/16/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat HHA due to Encounter For Other Orthopedic Aftercare 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 PT Eval Notes: OT Eval Notes:
 Physician Wilson, Marc

SN Careplans | SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 10/21/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Marc Wilson
815 E Pratt St
Baltimore, MD 21202
PHONE: 410-637-5700 FAX: 1-410-637-5701 NPI: 1275565251

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 : 10/16/2025

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.

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SN WK1: 1 (10/21/25-10/25/25) ,WK2: 1 (10/26/25-11/01/25) ,WK3: 1 (11/02/25-11/08/25) ,WK4: 1 (11/09/25-11/15/25)

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: 7. Currently taking 5 or more medications

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; 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, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, limited range of motion, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, B1000 - Vision Deficit, #1 - Non-Observable Surgical Wound - Posterior Left Neck - Dressing to be removed 5 days post op and left open to air.

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: To posterior neck surgical site- Remove dressing 5 days post op. Leave open to air, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, 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, * 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, * how to promote optimized mobility with strength balance dexterity range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing prevent constipation, 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

PATIENT-STATED GOAL: "To get better and back to being myself."

GOALS
patient/caregiver recalls
* how to promote optimized mobility with strength
* balance
* dexterity
* range-of-motion therapeutic exercises
* promotion of peripheral circulation
* fluid and diet intake to promote healing
* prevent constipation
* 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
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient is adequately supervised

caregiver performs medical/rehabilitation treatments with adequate competence

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

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 2 (10/21/25-10/25/25) ,WK2: 2 (10/26/25-11/01/25) ,WK3: 1 (11/02/25-11/08/25) ,WK4: 1 (11/09/25-11/15/25) ,WK5: 1 (11/16/25-11/22/25) ,WK6: 1 (11/23/25-11/29/25)

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: Home exercise program : Supine hip flexion, bridging, straight leg raise. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps , Bed mobility training: Follow spinal precautions, Postural training, 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 - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 _ Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT Goals

PATIENT-STATED GOAL: To walk independently to the bus stop

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Car Transfer - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	10/21/2025

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recalls related medication(s) purpose, schedule

Sit to Stand - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 _ Step (curb) - 06. Independent

OT Careplans

OT WK2: 1 (10/26/25-11/01/25) ,WK3: 1 (11/02/25-11/08/25) ,WK4: 1 (11/09/25-11/15/25) ,WK5: 1 (11/16/25-11/22/25) ,WK6: 1 (11/23/25-11/29/25) ,WK7: 1 (11/30/25-12/06/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

PROCEDURES: cough/deep breathing exercises, incentive spirometer, 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, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 06. Independent, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: Pt wants to go back to PLOF

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

Lower Body Dressing - 06. Independent

Shower/Bathe Self - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
10/21/2025