Home Health Certification and Plan of Care

Order ID: 1150/14865

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
081139693	12/12/2025	From: 12/12/2025 To: 02/09/2026	20101	217058

6. Patient's Name and Address

Elanda Gaither
6215 Seton Hills Lane,
GWYNN OAK, MD 21207-
443-850-0653

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 12/04/1963 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.89	Encounter for other orthopedic aftercare	12/12/25

13. ICD	Other Pertinent Diagnoses	Date
M48.02	Spinal stenosis cervical region	12/12/25
G95.89	Other specified diseases of spinal cord	12/12/25
I10.	Essential (primary) hypertension	12/12/25
E11.9	Type 2 diabetes mellitus without complications	12/12/25
I42.1	Obstructive hypertrophic cardiomyopathy	12/12/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	12/12/25
E78.5	Hyperlipidemia unspecified	12/12/25
J44.89	Other specified chronic obstructive pulmonary disease	12/12/25
K76.0	Fatty (change of) liver not elsewhere classified	12/12/25
N13.9	Obstructive and reflux uropathy unspecified	12/12/25
F40.240	Claustrophobia	12/12/25
F41.9	Anxiety disorder unspecified	12/12/25
M19.90	Unspecified osteoarthritis unspecified site	12/12/25
K21.9	Gastro-esophageal reflux disease without esophagitis	12/12/25
R91.1	Solitary pulmonary nodule	12/12/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	12/12/25
Z98.1	Arthrodesis status	12/12/25
Z99.89	Dependence on other enabling machines and devices	12/12/25
Z87.891	Personal history of nicotine dependence	12/12/25
Z87.01	Personal history of pneumonia (recurrent)	12/12/25

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

Lipitor - Atorvastatin Calcium 40 mg tablet, Take 1 tablet by mouth once a day
Verapamil - Verapamil Hydrochloride 180 mg CR tablet,Take 2 tablets by mouth as necessary (360 mg total) by mouth
Ditropan - Oxybutynin Chloride 5 mg tablet Take 1 tablet by mouth at bedtime by mouth in the morning and 1 tablet (5 mg total) before bedtime.
Spiriva - Tiotropium Bromide Monohydrate 18 mcg per inhalation,Place 2 puffs inhalant once a day into inhaler and inhale 1 (one) time each day
Lyrica - Pregabalin 75 mg by mouth twice a day New pain medication Take on in the morning and one at bedtime
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg by mouth every 4 hours Pain medication Every 4 hours as needed for pain
Lantus - Insulin Glargine Recombinant 15 Units subcutaneous in the morning
Diazepam - Diazepam 5 mg by mouth at bedtime To assist with sleep
Diphenhydramine-zinc acetate cream 2% topical three times a day Apply to rash on back and buttocks in the morning, evening and at bedtime.
Loratidine - Loratadine 10mg tablet by mouth once a day For allergies
Baclofen - Baclofen 5mg- one tablet by mouth three times a day Muscle relaxer one in the morning, one in the evening and one at bedtime
Acetaminophen - Acetaminophen 650 mg by mouth every 6 hours As needed for pain
Lasix - Furosemide 20 mg by mouth as necessary Every other day for swelling of BLE

14. DME and Supplies:

diabetic supplies, commode, walker

15. Safety Measures:

bathroom safety, medication safety, diabetic precautions, fall precautions, walker precautions, transfer with assist, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

bupropion cipro chlorpromazine latex albuterol alendronate atenolol tramadol d

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

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: 0. Never, 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

family/caregiver 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 62-year-old female with a past medical history significant for anemia, anxiety, asthma, fatty liver disease, GERD, claustrophobia, hyperlipidemia, hypertension, hypertrophic obstructive cardiomyopathy, neck pain, obstructive sleep apnea, osteoarthritis, prediabetes, and ulcerative colitis. She was admitted to home health services following cervical spine surgery for cervical myelopathy, including anterior cervical decompression and fusion (C2-3), anterior cervical discectomy and fusion with instrumentation from C2-T1, removal of hardware, posterior cervical fusion from the occiput to T2, and a partial thyroidectomy. She requires skilled PT and OT services as well as medication education. The patient is currently wearing a rigid cervical collar at all times except when showering and is maintaining cervical spinal precautions. Surgical incisions are healed; however, she reports an itchy rash on her back and buttocks that began during hospitalization and is being treated with prescribed topical medication. Medication reconciliation was completed with her daughter, as the patient reported difficulty keeping up with new medications, and medication education is included in the plan of care. On assessment, vital signs were obtained and the patient was admitted to home health. She resides with her daughter in a multilevel home with a first-floor setup and is currently sleeping in a recliner. Prior to hospitalization, she ambulated with a rollator at modified independence but had difficulty with stairs due to knee pain. Currently, she demonstrates decreased bilateral lower extremity strength (3/5 MMT), requires contact guard assistance for transfers and short-distance ambulation with a rolling walker, and is unable to attempt stair negotiation due to pain. She requires moderate assistance with lower body dressing, minimal assistance with upper body dressing, contact guard assistance for sit-to-stand and toilet transfers with verbal cueing, and assistance with sink-side bathing due to cervical precautions and inability to reach overhead. Her daughter assists with medication management, bathing, dressing, and all instrumental activities of daily living. The patient was instructed in seated lower extremity therapeutic exercises and encouraged to ambulate at least every two hours to avoid prolonged sitting. She would benefit from continued skilled PT and OT services to improve strength, balance, safety, and functional mobility in order to return to her prior level of function.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 12/12/2025<o:p></o:p> Order<o:p></o:p> Physician Face-to-Face Date: 11/27/2025
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hhadl's dx: Encounter for other orthopedic aftercare
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches,

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 12/12/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Neelofar Wajahat
7141 Security Blvd
Baltimore, MD 21244
PHONE: 855-902-4974 FAX: 14108473396 NPI: 1083861181

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 : 11/27/2025

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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a walker, or a wheelchair to leave home<o:p></o:p>
 1 - SOC - SN Notes: PT Eval Notes:
 OT Eval Notes:<o:p></o:p> Physician: Wajahat, Neelofar<o:p></o:p>

SN Careplans

SN WK1: 1 (12/12/25-12/13/25) ,WK2: 2 (12/14/25-12/20/25) ,WK3: 2 (12/21/25-12/27/25)

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, blood sugar < 60 > 300

CAREGIVER: 1. Non-agency caregiver(s) currently 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; 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, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, heartburn/indigestion, limited range of motion, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, weak hand grips, new incidence of rash, itchy skin

PROCEDURES: 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 optimize mental status with cognition therapy home safety optimize mobility with active and passive range of motion therapeutic exercises diet and fluids to optimize peripheral circulation, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule

SN Goals

PATIENT-STATED GOAL: I want to be more independent and get this collar off.

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 optimize mental status with cognition therapy
* home safety
* optimize mobility with active and passive range of motion therapeutic exercises
* diet and fluids to optimize peripheral circulation
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

PT Careplans

PT WK2: 1 (12/14/25-12/20/25) ,WK3: 1 (12/21/25-12/27/25) ,WK4: 1 (12/28/25-01/03/26) ,WK5: 1 (01/04/26-01/10/26) ,WK6: 1 (01/11/26-01/17/26) ,WK7: 1 (01/18/26-01/24/26) ,WK8: 1 (01/25/26-01/31/26) ,WK9: 1 (02/01/26-02/07/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, 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),

PT Goals

PATIENT-STATED GOAL: To be independent

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/12/2025

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GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, Review cervical precautions: no bending or twisting neck, lifting more than 5lb , cough/deep breathing exercises, gait training on uneven surfaces, gait training/stair training, transfers training, therapeutic 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 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, 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, 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, Medication Review

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

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

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

Medication Review

OT Careplans

OT WK1: 6 (12/12/25-12/13/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: ADLS , Functional ambulation , Medication reviewed with patient/caregiver : Medication review , cough/deep breathing exercises, therapeutic 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

OT Goals

PATIENT-STATED GOAL: Patient wants to get to the bathroom independently and by herself

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/12/2025