

Home Health Certification and Plan of Care										Order ID: 1150/15013			
1. Patient s HI claim No.			2. Start Of Care Date			3. Certification Period			4. Medical Record No.			5. Provider No.	
6C53DT1RR77			12/16/2025			From: 12/16/2025 To: 02/13/2026			20550			217058	
6. Patient's Name and Address Donald Brown 1817 FORREST ROAD, PARKVILLE, MD 21234- 410-661-4445						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 09/08/1944 9.Sex Male						10. Medications: Dose/Frequency/Route (N)ew (C)hanged							
11. ICD		Principal Diagnosis				Date		Crestor - Rosuvastatin Calcium 20 mg 1 tablet by mouth once a day to lower my cholesterol Toprol XL - Metoprolol Tartrate 25 mg, take 1 tablet by mouth at bedtime for blood pressure control Pepcid - Famotidine 20 mg 1 tablet by mouth at bedtime for upset stomach or GERD Protonix - Pantoprazole Sodium eq 40 mg base 1 tablet by mouth once a day before breakfast for GERD Acetaminophen - Acetaminophen 650 mg 2 tablet by mouth as necessary three times a day for pain Aspirin 81Mg - Aspirin 1 tablet by mouth once a day for heart health Flomax - Tamsulosin Hydrochloride 0.4 mg 1 capsule by mouth once a day for my prostate Allopurinol - Allopurinol 100 mg 1 tablet by mouth once a day for my gout Albuterol - Albuterol 0.09 mg/inh 1 puff inhalant every 4 hours as needed for shortness of breath, wheezes Benzonatate - Benzonatate 100 mg 1 capsule by mouth three times a day for cough and cold Mucinex Dm - Dextromethorphan Hydrobromide: Guaifenesin 30 mg;600 mg 1 tablet by mouth twice a day as needed for cough or congestive Lidocaine Patch - Lidocaine 4% patch topical as necessary for pain Prednisone - Prednisone 20 mg 2 tablets by mouth once a day Artificial Tears - Normal Saline 0.1%-0.2%, 1 drop both eyes at bedtime for dry eyes Demadex - Torsemide 20 mg 1 tablet by mouth once a day for fluid control Cozaar - Losartan Potassium 25 mg 1 tablet by mouth once a day for blood pressure control Amiodarone - Amiodarone Hydrochloride 100 mg, take 1 tablet by mouth once a day for heart and blood pressure Imdur - Isosorbide Mononitrate 30 mg 1 tablet by mouth once a day for my heart Ranexa - Ranolazine 500 mg 1 tablet by mouth once a day for chest pain Salonpas - Menthol: Methyl Salicylate 3 perc;10 perc 1 patch transdermal as necessary every 24 hours Tapazole - Methimazole 10 mg 1 tablet by mouth once a day for my thyroid Polyethylene Glycol - Polyethylene Glycol 3350: Potassium Chloride: Sodium Bicarbonate: Sodium Chloride 17 gm by mouth as necessary mix in 8 ounces of fluid daily for constipation Tramadol Hydrochloride - Tramadol Hydrochloride 50 mg 1 tablet by mouth as necessary every 6 hours as needed for pain					
S22.069D		Unsp fracture of T7-T8 vertebra subs for fx w routn heal				12/16/25							
13. ICD		Other Pertinent Diagnoses				Date							
E05.90		Thyrotoxicosis unsp without thyrotoxic crisis or storm				12/16/25							
I48.91		Unspecified atrial fibrillation				12/16/25							
M81.0		Age-related osteoporosis w/o current pathological fracture				12/16/25							
M54.9		Dorsalgia unspecified				12/16/25							
M48.10		Ankylosing hyperostosis [Forestier] site unspecified				12/16/25							
I11.0		Hypertensive heart disease with heart failure				12/16/25							
I50.20		Unspecified systolic (congestive) heart failure				12/16/25							
I25.10		Athscl heart disease of native coronary artery w/o ang pctrs				12/16/25							
I25.2		Old myocardial infarction				12/16/25							
K22.70		Barrett's esophagus without dysplasia				12/16/25							
D63.8		Anemia in other chronic diseases classified elsewhere				12/16/25							
K21.9		Gastro-esophageal reflux disease without esophagitis				12/16/25							
G47.30		Sleep apnea unspecified				12/16/25							
M10.9		Gout unspecified				12/16/25							
E78.5		Hyperlipidemia unspecified				12/16/25							
Z91.81		History of falling				12/16/25							
Z85.820		Personal history of malignant melanoma of skin				12/16/25							
Z98.61		Coronary angioplasty status				12/16/25							
Z95.1		Presence of aortocoronary bypass graft				12/16/25							
Z79.82		Long term (current) use of aspirin				12/16/25							
Z87.891		Personal history of nicotine dependence				12/16/25							
14. DME and Supplies: rolling walker, hand held shower, commode, cane						15. Safety Measures: activity supervision							
16. Nutrition: Z. NO PHYSICIAN-ORDERED DIET						17. Allergies: iodinated contrast dye iodine lisinopril							
18.A. Functional Limitations Endurance, Hearing						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: 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 family/caregiver will be responsible for managing treatment							
Homebound status: Due to diagnosis of Unspecified Fracture Of T7-T8 Vertebra, Subsequent Encounter For Fracture With Routine Healing, 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 RN on 12/16/2025										25. Date HHA Received Signed POT			
24. Physician's Name and Address Patricia Savadel 10755 Falls Rd Lutherville, MD 21093 PHONE: 4105837111 FAX: 14105837178 NPI: 1295736783						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 : 12/13/2025							
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							

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Clinical Condition Requiring Homecare:	<div>The patient is an 81-year-old male presenting with severe upper back pain rated 9/10, generalized weakness, and an unsteady gait secondary to a nondisplaced compression fracture of the T7/T8 vertebrae, with a past medical history significant for osteoporosis and thyroid disease. Additional extensive past medical history includes atrial fibrillation (not on anticoagulation due to iron deficiency), acute myocardial infarction, Barrett syndrome, coronary artery disease, cataracts, enlarged prostate, gastroesophageal reflux disease, gout, hiatal hernia, hyperlipidemia, hypertension, melanoma, osteoarthritis, and sleep apnea. The patient was recently hospitalized at St. Joseph Medical Center from 11/23 to 11/26 for influenza A, during which he received steroid therapy and was found to have abnormal thyroid function tests. Endocrinology was consulted, and the patient was started on methimazole and discharged on continued steroids.&nbsp; The patient subsequently presented to the emergency department after slipping on a rug at home and landing on his back, resulting in severe upper back pain. He denied loss of consciousness and was placed in a cervical collar as a precaution. A CT scan of the head was unremarkable, while a CT scan of the thoracic spine revealed a nondisplaced fracture through the T8 vertebral body. Pain control with oxycodone in the emergency department was initially inadequate, and due to uncontrolled pain and inability to safely discharge home, the patient was placed under observation. His pain improved with continued oxycodone administration. He also reported a cough during hospitalization. A spine surgery consultation was obtained, and conservative management with physical therapy was recommended.&nbsp; At today's home visit, the patient was found to be living alone and ambulating without an assistive device, reporting persistent severe back pain rated 9/10 and stating that his pain medication was no longer effective. Medication reconciliation revealed that he is currently taking aspirin (NSAID) and tramadol for pain management and is no longer receiving oxycodone as he did during hospitalization. The patient was educated on nonpharmacologic pain management strategies, including the use of hot and cold packs and topical pain patches to assist with pain reduction. Education was provided regarding vertebral fracture precautions, including no bending, lifting, or twisting, the importance of sitting in chairs with back support, avoiding low seating surfaces, and the consistent use of a walker for all ambulation.&nbsp; Occupational therapy adjusted the patient's walker and instructed him on proper use to reduce strain on his back during standing and ambulation. The patient demonstrated appropriate use of the walker and reported decreased back discomfort with its use. A home safety <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> revealed the presence of carpet and throw rugs, which were identified as fall hazards; the patient was educated on the risks and the need for removal. The patient is currently independent with activities of daily living, including shower transfers, though he was educated on the benefits of using a shower chair for increased safety. Prior to this injury, the patient was independent, able to drive, and ambulated with a cane. At present, he is avoiding activity and is unable to exit the home due to pain and instability.&nbsp; The patient was instructed in gentle exercises to be performed in a seated position only, in accordance with spinal precautions. Given the patient's ongoing pain, impaired mobility, and recent decline from baseline function, he would benefit from skilled physical therapy services to address gait, strength, balance, and safe mobility. No further skilled occupational therapy services are indicated at this time, as identified occupational therapy goals have been addressed.</div><div>
</div><div> </div><div>Date of Order</div><div>12/16/2025</div><div>Orders</div><div>Physician Face-to-Face Date: 12/13/2025</div><div>Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat OT-eval & treat due to Unspecified Fracture Of T7-T8 Vertebra, Subsequent Encounter For Fracture With Routine Healing</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>1 - SOC - OT Notes: soc - OT</div><div>PT Eval Notes:</div><div>
</div><div>Physician</div><div>Savadel, Patricia</div>					
SN Careplans			SN Goals			
PT Careplans			PT Goals			
PT WK1: 1 (12/16/25-12/20/25) ,WK3: 1 (12/28/25-01/03/26) ,WK4: 1 (01/04/26-01/10/26) ,WK5: 1 (01/11/26-01/17/26) ,WK6: 1 (01/18/26-01/24/26) ,WK7: 1 (01/25/26-01/31/26) 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, cough/deep breathing exercises, incentive spirometer, seated strengthening exercises: SLR, Long arc, marching , knee abd/add and heel/toe raises ---10x2 rep, 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			PATIENT-STATED GOAL: To be pain free 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 - 06. Independent Walk 50 ft with 2 Turns - 06. Independent			
Signature of Physician:			Date			
			PAGE 2 of 3			
Optional Name/Signature of Nurse/Therapist:			Date			
Electronically Signed by Messick, Charles RN			12/16/2025			

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			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		
OT Careplans OT WK1: 1 (12/16/25-12/20/25) 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:Living Will PROBLEMS IDENTIFIED ON ASSESSMENT: GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, Home Safety, M2020 - Oral Med Management, M1400 - Dyspnea, abnormal thyroid <= 0.40 - 4.50 mIU/mL, upper back/flank pain, Pain Interference with ADLs, balance deficit, Pain Interference with Therapy activities, Pain Effect on Sleep, loss of appetite PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, equipment training, work simplification/energy conservation, teach/coordinate/arrange medication packaging and/or administration TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * 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, * prescribed dietary modifications monitoring intake and output monitoring weight loss or weight gain monitor changes in neurological status, related medication(s) purpose, schedule, * pain control therapeutic exercises to optimize range of motion of affected area diet and fluids to promote healing, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient living environment has safe floor coverings, caregiver administers and/or packages medications appropriately, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent			OT Goals PATIENT-STATED GOAL: to get relief from my back pain GOALS patient/caregiver recalls * pain control * therapeutic exercises to optimize range of motion of affected area * diet and fluids to promote healing * recalls related medication(s) purpose, schedule patient/caregiver recalls * prescribed dietary modifications * monitoring intake and output * monitoring weight loss or weight gain * monitor changes in neurological status * recalls related medication(s) purpose, schedule 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 * 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 * 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 patient living environment has safe floor coverings caregiver administers and/or packages medications appropriately caregiver administers and/or packages medications appropriately caregiver performs medical/rehabilitation treatments with adequate competence Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Shower/Bathe Self - 06. Independent Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent		
Signature of Physician:			Date		
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