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

11. ICD	Principal Diagnosis	Date
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

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

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

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 **12/23/2025**: 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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Clinical Condition Requiring Homecare:

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. 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. 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. 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. 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.
 Date of Order 12/16/2025 Orders Physician Face-to-Face Date: 12/13/2025 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 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 - OT Notes: soc - OT PT Eval Notes:
 Physician Savadel, Patricia

SN Careplans

SN Goals

PT Careplans

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

PT Goals

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

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

Date
12/16/2025