Home Health Certification and Plan of Care

Order ID: 1150/15865

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
141028619	01/28/2026	From: 01/28/2026 To: 03/28/2026	21811	217058

6. Patient's Name and Address

Patrick Milani
9402 Armada Way,
ROSEDALE, MD 21237-
410-687-8413

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 04/28/1961 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
M51.17	Intvrt disc disorders w radiculopathy lumbosacral region	01/28/26

13. ICD	Other Pertinent Diagnoses	Date
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	01/28/26
G95.20	Unspecified cord compression	01/28/26
I87.002	Postthrombotic syndrome w/o complications of l low extrem	01/28/26
E66.3	Overweight	01/28/26
Z68.41	Body mass index [BMI] 40.0-44.9 adult	01/28/26
Z85.048	Prsnl hx of malig neoplm of rectum rectosig junct and anus	01/28/26
Z86.718	Personal history of other venous thrombosis and embolism	01/28/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	01/28/26
Z79.82	Long term (current) use of aspirin	01/28/26
Z91.81	History of falling	01/28/26

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

Mobic - Meloxicam 7.5 mg 1 Tablet by mouth twice a day
Neurontin - Gabapentin 400 mg 1 Capsule by mouth twice a day for 30 days
Ibuprofen - Ibuprofen 200 mg 1 tab by mouth every 6 hours Take 1 tab every 6 hours as needed for pain
Aspirin - Aspirin 81 MG Oral Tablet , Take 1 tablet by mouth once a day Take 1 tab daily for cardiac prevention method

14. DME and Supplies:

hospital bed, rolling walker

15. Safety Measures:

walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with device, ambulates with assistance, , supervision at all times, wheelchair precautions, , , , activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Transfer bed/Chair, Exercises Prescribed, 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: fair

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status:

Due to diagnosis of Intervertebral Disc Disorders With Radiculopathy, Lumbosacral Region, 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 64-year-old male who resides alone in the basement level of a single-family home and is currently wheelchair bound. He was referred to home health services following a telehealth appointment with his provider, as he is unable to leave the home due to impaired mobility. The patient's primary complaints include severe right knee pain and swelling following recurrent falls, with the most recent fall resulting in head impact. He reports right knee pain rated at 10/10 and states that his current pain management regimen of meloxicam is ineffective. He previously took oxycodone 5 mg for pain control; however, his provider has declined to prescribe opioids at this time. The patient has no known drug allergies, all medications are present in the home, and medication review was completed. The patient is status post lumbosacral spinal surgical repair and reports that approximately one month after surgery, he sustained a fall in which he injured his right knee. On assessment, the right knee is visibly swollen, painful, and demonstrates grossly limited active range of motion. The patient reports that he has spoken with his surgeon and is awaiting approval from Kaiser Permanente for diagnostic imaging, including an X-ray and MRI of the right knee. He was instructed by his surgeon to remain non-weight bearing on the right lower extremity until imaging results are available. The patient is currently wheelchair dependent and requires assistance with transfers and most activities of daily living. The patient's past medical history is significant for post-thrombotic syndrome of the left leg, overweight status, rectal cancer, history of deep vein thrombosis, lumbosacral disc degeneration, history of lumbosacral spine surgery, lumbosacral radiculopathy, and type 2 diabetes mellitus with polyneuropathy. He is a full code, and there is no MOLST on file. He receives intermittent assistance from a cousin for activities of daily living; however, he does not have full-time caregiver support. Prior to his recent decline, the patient reports that he was able to perform basic self-care, functional transfers, and functional mobility independently. During the nursing visit, education was provided on safe transfer techniques and bed-level home exercises to promote safety and prevent further injury. Due to ongoing knee pain, swelling, and mobility restrictions, the patient demonstrates decreased standing balance, standing tolerance, bilateral upper extremity strength, and overall activity tolerance, resulting in significant limitations in self-care, functional transfers, and ambulation. The provider has ordered blood work to facilitate further evaluation and potential CT imaging of the right knee. Laboratory studies to be obtained at the next nursing visit include hemoglobin A1C, complete blood count, basic metabolic panel (Chem 7), and iron panel, with specimens to be delivered to a Kaiser laboratory. The patient was provided with contact information for remote radiology services to arrange the ordered right knee X-ray. Occupational therapy and home health aide services were recommended to assist with bathing and address functional deficits; however, the patient has declined OT and HHA services at this time, preferring to defer additional services until after completion of diagnostic imaging. No further OT services are planned at this time. The plan of care includes completion of ordered laboratory testing at the next visit, coordination of diagnostic imaging, continued nursing assessment and education, monitoring of pain and functional status, and reassessment of therapy needs once imaging results are available and weight-bearing status is clarified.
 Date of Order 01/28/2026 Orders Physician Face-to-Face Date: 01/23/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat due to Intervertebral Disc Disorders With Radiculopathy, Lumbosacral Region <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 01/28/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Jerome Chambers
4920 Campbell Blvd
White Marsh, MD 21236
PHONE: 14109337600 FAX: NPI: 1053978189

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 : 01/23/2026

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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14px;">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 Chambers, Jerome

SN Careplans

SN WK1: 1 (01/28/26-01/31/26) ,WK2: 1 (02/01/26-02/07/26) ,WK3: 1 (02/08/26-02/14/26) ,WK4: 1 (02/15/26-02/21/26) ,WK5: 1 (02/22/26-02/28/26) ,WK6: 1 (03/01/26-03/07/26) ,WK7: 1 (03/08/26-03/14/26) ,WK8: 1 (03/15/26-03/21/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 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, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, M1400 - Dyspnea, dependent edema, limited range of motion, muscle weakness, limited strength, limited endurance, swelling of affected area, poor muscle tone, Pain Effect on Sleep, balance deficit, weak hand grips, Pain Interference with ADLs, swell/redness surround. skin

PROCEDURES: incentive spirometer, apply anti-embolitic stockings, apply compression bandage, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

02/03/2026: Physician order lab work, CBC w/diff and ESR, Chem 7, A1C, iron, liver function test

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 medicatio, * 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 relaxatio, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

SN Goals

PATIENT-STATED GOAL: Patient states he wants to be able to get out of the house again as he has not been able to get outside in years.

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 medicatio

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 relaxatio

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

caregiver administers and/or packages medications appropriately

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

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PT WK1: 1 (01/28/26-01/31/26) ,WK2: 1 (02/01/26-02/07/26) ,WK3: 1 (02/08/26-02/14/26) ,WK4: 1 (02/15/26-02/21/26) ,WK5: 1 (02/22/26-02/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Effect on Sleep, GG0170M1 - 1 - Step (curb), GG0170S1 - Wheel 150 feet, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170F1 - Toilet Transfer, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand

PROCEDURES: Medication Review: The medication was reviewed with the patient , cough/deep breathing exercises, incentive spirometer, wheelchair training, 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 medicatio, * 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 relaxatio, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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, 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, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PATIENT-STATED GOAL: To walk again

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 medicatio

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 relaxatio

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

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

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

OT Careplans

OT WK2: 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, 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: Medication Review : Medication reviewed with patient with all medications in the home. , 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 medicatio, * 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 relaxatio, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Get out of the house

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 medicatio

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 relaxatio

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:

Date

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

Date
01/28/2026