Home Health Certification and Plan of Care

Order ID: 1150/16505

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
68159065	02/22/2026	From: 02/22/2026 To: 04/22/2026	19655	217058

6. Patient's Name and Address

Aaron Saunders
4822 Hamilton Ave apt 2C,
BALTIMORE, MD 21206-
443-991-2177

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 06/24/1952 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
M48.02	Spinal stenosis cervical region	02/22/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	02/22/26
M47.12	Other spondylosis with myelopathy cervical region	02/22/26
G95.89	Other specified diseases of spinal cord	02/22/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	02/22/26
E78.5	Hyperlipidemia unspecified	02/22/26
E55.9	Vitamin D deficiency unspecified	02/22/26
M19.90	Unspecified osteoarthritis unspecified site	02/22/26
D64.9	Anemia unspecified	02/22/26
Z79.52	Long term (current) use of systemic steroids	02/22/26
Z79.01	Long term (current) use of anticoagulants	02/22/26
Z85.46	Personal history of malignant neoplasm of prostate	02/22/26
Z86.711	Personal history of pulmonary embolism	02/22/26
Z98.1	Arthrodesis status	02/22/26
Z87.891	Personal history of nicotine dependence	02/22/26
Z87.440	Personal history of urinary (tract) infections	02/22/26

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

Lipitor - Atorvastatin Calcium 80 mg, Tablet by mouth once a day Cholesterol
Pradaxa - Dabigatran Etexilate Mesylate 150 mg , Tablet by mouth twice a day blood thinner
Flomax - Tamsulosin Hydrochloride 0.8 mg, Tablet by mouth at bedtime prostrate
Vitamin D - Ergocalciferol 50 MCG (2000 UT) CAPS, 1 tablet by mouth once a day supplement
Prednisone - Prednisone 5 mg, Tablet by mouth once a day steroids
Zytiga - Abiraterone Acetate 1,000 mg, Tablet by mouth once a day PROSTRATE
Tylenol - Acetaminophen 325mg, take 2 tablets by mouth every 6 hours mild pain
Ultram - Tramadol Hydrochloride 50 mg take 1 tablet by mouth every 8 hours Moderate pain
Zestril - Lisinopril 20 mg 10 mg 10mg, Tablet by mouth once a day HTN
Ativan - Lorazepam 0.5 mg 0.5mg by mouth twice a day As needed for anxiety

14. DME and Supplies:

hospital bed, , wheelchair, walker, bath bench

15. Safety Measures:

transfer with assist, toe-touch weight bearing LLE, , , supervision at all times, , , bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

low cholesterol, low sodium, cardiac diet

17. Allergies:

no known allergies

18.A. Functional Limitations

Hearing, Ambulation, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted

Walker, Wheelchair, 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: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans

patient will be responsible for managing treatment

Homebound status:

Due to diagnosis of Spinal Stenosis Cervical 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:

Start of care assessment completed following hospitalization and subsequent five-week stay in a skilled nursing facility for rehabilitation. All consents were reviewed with and signed by the patient. The patient is a 23-year-old male with a significant past medical history including deconditioning, prostate cancer, cervical spine myelomalacia and stenosis, generalized weakness, status post arthrodesis, benign prostatic hyperplasia (BPH), hyperlipidemia, vitamin D deficiency, anemia, long-term steroid and anticoagulant use, history of pulmonary embolism, nicotine use, and recurrent urinary tract infections. The patient presents with marked deconditioning and bilateral lower extremity weakness, resulting in impaired mobility and ambulatory dysfunction. He reports being unable to ambulate following his recent rehabilitation stay. Due to weakness and poor endurance, he requires an assistive device and supervision for ambulation and transfers to ensure safety and prevent falls, making it a considerable and taxing effort for him to leave the home. The patient is currently homebound. The patient resides with his son, Aaron, who provides assistance with care and medication administration. The son works mornings and returns home in the early afternoon. Medication reconciliation was performed; the patient reports that his son administers all prescribed medications daily, and the son denies any concerns regarding medication management. The patient is hard of hearing and utilizes hearing aids. He sleeps in a hospital bed and has durable medical equipment in the home including a wheelchair, rollator, and shower bench. Education was provided regarding safe operation of the hospital bed and general home safety measures. The patient wears incontinence garments for safety and requires assistance with mobility and transfers. Skin assessment revealed no open wounds. A small scabbed area was noted over the left clavicle and a raised circular area was observed on the right lower back; both areas were intact without signs of infection or abnormal bleeding. The patient denies any recent falls. His stated goal is to regain the ability to ambulate and perform self-care activities independently. Skilled nursing services are ordered at a frequency of once weekly for six weeks to monitor medical status, manage medications, reinforce safety and fall prevention strategies, and provide ongoing assessment. Physical therapy, occupational therapy, and home health aide services have also been initiated to address strengthening, mobility training, activities of daily living, and personal care needs as part of the comprehensive plan of care.
 Date of Order 02/22/2026 Orders Physician Face-to-Face Date: 01/31/2026 Clinical Condition Requiring home Care per Certifying Physician: sn-disease management due to Spinal Stenosis Cervical Region Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/22/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Justin Capasso
815 E Pratt Street
Baltimore, MD 21202
PHONE: 410-637-5700 FAX: 14106375701 NPI: 1457713331

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 : 01/31/2026

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;">
 1-SOC-SN Notes: SOC
 Physician Capasso, Justin

SN Careplans

SN WK1: 1 (02/22/26-02/28/26) ,WK2: 1 (03/01/26-03/07/26) ,WK3: 1 (03/08/26-03/14/26) ,WK4: 1 (03/15/26-03/21/26) ,WK5: 1 (03/22/26-03/28/26) ,WK6: 1 (03/29/26-04/04/26) ,WK7: 1 (04/05/26-04/11/26) ,WK8: 1 (04/12/26-04/18/26)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

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 ; 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, SpO_2: 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.

No open wounds noted
Advance Directive:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal blood pressure, poor muscle tone, limited endurance, muscle weakness, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, monitor intake & output, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: Get strength back to legs and walk

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

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/22/2026