Home Health Certification and Plan of Care

Order ID: 1150/16778

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01240676	03/02/2026	From: 03/02/2026 To: 04/30/2026	23098	217058

6. Patient's Name and Address

Donald Spencer
3320 Barrington Road,
BALTIMORE, MD 21215-
443-803-1005

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 05/09/1951 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
M48.061	Spinal stenosis lumbar region without neurogenic claud	03/02/26

13. ICD	Other Pertinent Diagnoses	Date
Z47.89	Encounter for other orthopedic aftercare	03/02/26
E11.69	Type 2 diabetes mellitus with other specified complication	03/02/26
E78.5	Hyperlipidemia unspecified	03/02/26
I10.	Essential (primary) hypertension	03/02/26
K21.9	Gastro-esophageal reflux disease without esophagitis	03/02/26
M17.12	Unilateral primary osteoarthritis left knee	03/02/26
M47.896	Other spondylosis lumbar region	03/02/26
E66.9	Obesity unspecified	03/02/26
Z68.33	Body mass index [BMI] 33.0-33.9 adult	03/02/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	03/02/26
Z86.0101	Personal history of adeno	03/02/26

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

Baclofen - Baclofen 10 mg 1 tablet by mouth three times a day As needed for spasms
Roxicodone - Oxycodone Hydrochloride 5 mg 5 mg / 1 Tablet by mouth every 4 hours as needed for severe pain
Extra Strength Tylenol - Acetaminophen 500 mg, 2 tablets by mouth every 6 hours As needed for pain
Healfast 5 tablets by mouth twice a day Supplement
Norvasc - Amlodipine Besylate eq 10 mg base eq 10 mg base / 1 Tablet by mouth once a day Blood pressure
Metformin - Metformin Hydrochloride 500 mg tablet by mouth in the evening DM
Lipitor - Atorvastatin Calcium eq 40 mg base eq 40 mg base / 1 Tablet by mouth once a day for cholesterol and heart protection
COZAAR 0 100 mg / 1 Tablet by mouth once a day Blood pressure
Liposomal-glutathione 1 tablet by mouth once a day Supplement
probiotics 60 billion, 1 tablet by mouth once a day Supplement
Vitamin C - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tablet, 1000mg by mouth once a day Supplement
Prilosec Otc - Omeprazole Magnesium eq 20 mg base 1 tablet by mouth once a day Heart burn
Xalatan - Latanoprost 0 0.005 perc / Instill 1 drop right eye in the evening Glaucoma

14. DME and Supplies:

rolling walker, wheelchair, , cane, bath bench, diabetic supplies

15. Safety Measures:

remove environmental barriers, , , emergency phone number prominently displayed, electrical safety measures, , diabetic precautions, bathroom safety, avoid temperature extremes, ambulates with device, ambulates with assistance, Spinal precautions

16. Nutrition:

diabetic

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance,

18.B. Activities Permitted

Up As Tolerated, Exercises Prescribed, Spinal precautions

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

patient will be responsible for managing treatment

Homebound status:

Due to diagnosis of Spinal Stenosis Lumbar Region Without Neurogenic Claudication, 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 (SOC) assessment was completed for a 74-year-old male recently discharged following hospitalization for a lumbar laminectomy. The patient's past medical history is significant for diabetes mellitus, hypertension, right total knee arthroplasty (TKA), and prior hernia repair. Prior to surgery, the patient was independent with activities of daily living and functional mobility, typically ambulating without an assistive device, though he occasionally used a single-point cane for support. At the time of the home health evaluation, the patient demonstrates decreased bilateral lower extremity strength with manual muscle testing graded at approximately 3+/5. Due to postoperative weakness and decreased functional mobility, the patient currently requires minimal assistance for transfers and short-distance ambulation using a rolling walker. The patient resides alone in a single-story home; however, his significant other is temporarily staying with him to assist with activities of daily living including dressing, bathing, and meal preparation during the recovery period. Education was provided to both the patient and caregiver regarding spinal precautions related to activities of daily living and safe mobility following lumbar surgery. Instruction included proper body mechanics, avoidance of bending, lifting, and twisting, and strategies to maintain spinal alignment during functional tasks. The patient and caregiver verbalized understanding of the precautions and demonstrated receptiveness to the teaching provided. Given the patient's current functional limitations, skilled physical therapy services are medically necessary to address decreased lower extremity strength, impaired balance, and reduced safety with transfers and ambulation. Physical therapy interventions will focus on strengthening exercises, gait training, balance training, and functional mobility activities in order to improve safety and promote a return to the patient's prior level of function. Additionally, occupational therapy services are recommended at a frequency of once weekly for four weeks to address activities of daily living, adaptive equipment training, therapeutic exercises, development of a home exercise program, functional mobility training, and home safety education. The overall plan of care is aimed at improving the patient's independence, reducing fall risk, and supporting safe recovery in

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/02/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Gin Khai
7670 Quarterfield Rd
Glen Burnie, MD 21061
PHONE: 410-508-7650 FAX: NPI: 1003443078

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 : 02/24/2026

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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the home environment following lumbar spine surgery.
 Date of Order 03/02/2026 Orders Physician Face-to-Face Date: 02/24/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT eval and treat OT eval and treat due to Spinal Stenosis Lumbar Region Without Neurogenic Claudication 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 - PT Notes: soc OT Eval Notes:
 Physician Khai, Gin

SN Careplans

SN Goals

PT Careplans

PT WK1: 2 (03/02/26-03/07/26) ,WK2: 2 (03/08/26-03/14/26) ,WK3: 2 (03/15/26-03/21/26) ,WK4: 1 (03/22/26-03/28/26)

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: 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), 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, GG0170F1 - Toilet Transfer, M2020 - Oral Med Management, M2102d -

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

GOALS
Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up 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

Car Transfer - 05. Setup or clean-up assistance

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

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

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/02/2026

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Caregiver Performs Treatment, M2102c - Med Admin, M1400 - Dyspnea, limited endurance, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit

PROCEDURES: Review spinal precautions: no bending or twisting, lifting more than 5lb , cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: Leave incision on back covered with dressing for 5 days, then remove and leave open to air, therapeutic exercises, gait training/stair training, transfers training, teach/coordinate/arrange medication packaging and/or administration

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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

OT Careplans

OT WK1: 1 (03/02/26-03/07/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: cough/deep breathing exercises, 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 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: To be able to manage by myself

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
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