Home Health Certification and Plan of Care

Order ID: 1150/18469

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
40024956800	04/30/2026	From: 04/30/2026 To: 06/28/2026	5412	217058

6. Patient's Name and Address

Jamal Sally
5359 Columbia Rd Apt F,
COLUMBIA, MD 21044-
301-312-0976

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 03/08/1975 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z48.3	Aftercare following surgery for neoplasm	04/30/26

13. ICD	Other Pertinent Diagnoses	Date
D43.4	Neoplasm of uncertain behavior of spinal cord	04/30/26
Z98.1	Arthrodesis status	04/30/26
E11.9	Type 2 diabetes mellitus without complications	04/30/26
I10.	Essential (primary) hypertension	04/30/26
J45.20	Mild intermittent asthma uncomplicated	04/30/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	04/30/26
S31.109D	Unsp opn wnd abd wall unsp q w/o penet perit cav subs	04/30/26
E11.69	Type 2 diabetes mellitus with other specified complication	04/30/26
N52.9	Male erectile dysfunction unspecified	04/30/26
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	04/30/26
M47.26	Other spondylosis with radiculopathy lumbar region	04/30/26
Z86.718	Personal history of other venous thrombosis and embolism	04/30/26
E66.01	Morbid (severe) obesity due to excess calories	04/30/26
Z68.42	Body mass index [BMI] 45.0-49.9 adult	04/30/26
Z79.01	Long term (current) use of anticoagulants	04/30/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	04/30/26

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

Miralax - Polyethylene Glycol 3350 17gm/scoopful 17mg; 1 scoop by mouth every 12 hours as needed for constipation
Cozaar - Losartan Potassium 100 mg 100mg; 1 tab by mouth at bedtime for blood pressure control
Hydralazine - Hydralazine Hydrochloride 25mg; 1 tab by mouth three times a day blood pressure
Metoprolol Tartrate - Metoprolol Tartrate 50 mg 50mg; 1 tab by mouth twice a day blood pressure
Cyclobenzaprine - Cyclobenzaprine Hydrochloride 10mg; 1 tab by mouth every 8 hours for muscle spasms
Lipitor - Atorvastatin Calcium eq 20 mg base 20 mg, Take 1 tablet by mouth once a day For cholesterol and heart protection
Neurontin - Gabapentin 300 mg 300 MG, capsule by mouth every 8 hours neuropathy
Duloxetine Hydrochloride - Duloxetine Hydrochloride 30 mg 30mg; 1 tab by mouth once a day depression
Glucophage Xr - Metformin Hydrochloride 500 mg 500 MG tablet, Take 1 tablet by mouth three times a day DM
Eliquis - Apixaban 5MG; 1 TAB by mouth twice a day HX OF PE
Proventil - Albuterol 0.09 mg/inh 90 mcg, Inhale 2 puffs inhalant every 4 hours for shortness of breath (Rescue inhaler)
Lidocaine - Lidocaine 4%; 1 patch transdermal once a day apply to back for pain

14. DME and Supplies:

bath bench, walker, cane

15. Safety Measures:

standard precautions, no bending, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, no lifting, anticoagulant precautions, activity supervision

16. Nutrition:

diabetic, , 2gm sodium, cardiac diet, low cholesterol

17. Allergies:

pcn

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Exercises Prescribed, Walker,

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: Yes

20. Prognosis: fair

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: After undergoing C2-c5 laminectomy, right c3-c4 foraminotomy, and c2-c6 posterior spinal fusion performed for intradural tumor resection, 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: Patient is a 51-year-old male recently discharged from rehabilitation status post C2-C5 laminectomy, right C3-C4 foraminotomy, and C2-C6 posterior spinal fusion for intradural tumor resection. Past medical history is significant for congestive heart failure, hypertension, severe obesity with BMI 45-49.9, type 2 diabetes mellitus with neuropathy, osteoarthritis of the right knee status post total knee replacement in June 2024, intermittent asthma, history of pulmonary embolus, chronic back muscle spasms, constipation, gastroesophageal reflux disease, and opioid use disorder with opioid intoxication. Skilled nursing frequency ordered for 1 visit weekly for 12 weeks with 2 PRN <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh>, and PT/OT evaluations were ordered. During skilled nursing assessment, patient was noted with severely elevated blood pressure of 210/120 mmHg and heart rate in the low 100s. Patient reported shortness of breath when lying flat, intermittent difficulty breathing, and inability to sleep well the previous night due to dyspnea. Lung sounds were diminished throughout. Patient admitted to not taking prescribed medications that day except for Gabapentin. Due to history of pulmonary embolism, uncontrolled hypertension, edema, and respiratory complaints, emergency medical services were activated and patient was transported to the emergency room for further evaluation. Follow-up communication revealed patient was not admitted; patient reported receiving antihypertensive medication, IV treatment for lower extremity edema, and respiratory treatments prior to discharge home. Skilled nursing reviewed discharge paperwork and medications during follow-up visit and suspected medication noncompliance. Extensive education was provided regarding the importance of medication adherence, disease management, and monitoring for worsening cardiopulmonary symptoms. Patient continues to wear cervical neck collar as ordered and was instructed to maintain use until follow-up with surgeon per discharge instructions. Patient lives alone in an apartment, with son serving as primary caregiver and assisting as needed. Patient remains homebound due to impaired mobility, weakness, decreased endurance, dyspnea with exertion, balance deficits, fall risk, and postoperative restrictions. Patient reported a history of progressive balance impairment and falls from 2024 through 2025, eventually leading to MRI evaluation that revealed a cervical mass requiring surgical removal in March 2026. Patient ambulates independently indoors with a cane for short distances and uses a rolling walker for longer distances and community mobility. Patient demonstrates bilateral lower extremity weakness, impaired standing balance, altered gait mechanics, decreased endurance, and instability during ambulation. Ambulation is limited to household distances, and patient requires standby assistance for bed mobility and transfers with minimal assistance/contact guard assist during gait activities. Patient also reports bilateral hand numbness, upper extremity weakness, dropping objects, impaired fine motor coordination, clumsiness, tingling sensation in lower extremities, and reduced sensation

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/30/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Felecia Waddleton Willis
7070 Samuel Morse Dr
Columbia, MD 21046
PHONE: FAX: NPI: 1366673097

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 : 04/28/2026

27. Attending Physician's Signature and Date Signed **05/12/2026**: 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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to the plantar aspect of the right foot. Patient performs basic ADLs with supervision, frequent rest breaks, and increased time due to fatigue, weakness, and shortness of breath. Patient additionally reports left knee joint pain and difficulty sleeping supine secondary to asthma and dyspnea, preferring side-lying positioning for comfort. Physical assessment revealed patient awake, alert, oriented, and responsive. Surgical incision site appeared closed with scar tissue formation and no reported complications at time of visit. Patient continues to wear cervical brace at all times except during eating, drinking, showering, sleeping, or lying down per postoperative precautions. Skilled nursing reinforced fall prevention strategies, medication compliance, energy conservation techniques, and importance of adhering to postoperative precautions. Patient was instructed in deep breathing exercises as part of home exercise program to assist with respiratory status and endurance. Skilled PT services are medically necessary to address strengthening, balance retraining, gait training, endurance deficits, transfer safety, and fall prevention. Skilled OT services are required to improve hand strength, dexterity, coordination, fine motor function, safety with ADLs, and overall quality of life. Continued skilled nursing services are required for cardiopulmonary monitoring, medication management, postoperative assessment, disease process education, safety monitoring, and prevention of further hospitalization.
 Date of Order 04/30/2026 Orders Physician Face-to-Face Date: 04/28/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to C2-c5 laminectomy, right c3-c4 foraminotomy, and c2-c6 posterior spinal fusion performed for intradural tumor resection 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 OT Eval Notes: PT Eval Notes:
 Physician Waddleton Willis, Felecia

SN Careplans

SN WK1: 1 (04/30/26-05/02/26) ,WK2: 2 (05/03/26-05/09/26) ,WK3: 2 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/23/26)

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: 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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: D0160 - Depression, M2020 - Oral Med Management, Home Safety, meal preparation, M2102c - Med Admin, dependent edema, lung sounds not clear, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, limited endurance, balance deficit, Pain Interference with ADLs, obesity

PROCEDURES: cough/deep breathing exercises, coordinate/arrange for maintenance of clean/uncluttered living area

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,

SN Goals

PATIENT-STATED GOAL: I WANT TO GET STRONGER BEFORE I GO OUT. MY LEGS FEEL WEAK

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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient's living environment is clean/uncluttered

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/30/2026

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medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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's living environment is clean/uncluttered, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK2: 1 (05/03/26-05/09/26) ,WK3: 1 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/23/26) ,WK5: 1 (05/24/26-05/30/26) ,WK6: 1 (05/31/26-06/06/26) ,WK7: 1 (06/07/26-06/13/26) ,WK8: 1 (06/14/26-06/20/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, 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, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Medication Review-: Patient verbalized understanding of current prescriptions, dosages, and schedule. No reported issues with adherence, side effects, or confusion at this time., B LE strengthening: 1, Standing balance Training: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient verbalized understanding and demonstrated good carryover., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: not to go back to hospital

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

OT Careplans

OT WK2: 1 (05/03/26-05/09/26) ,WK3: 1 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/23/26) ,WK5: 1 (05/24/26-05/30/26) ,WK6: 1 (05/31/26-06/06/26) ,WK7: 1 (06/07/26-06/13/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing

PROCEDURES: Therapeutic activity : We've during the visit, cough/deep breathing exercises, incentive spirometer, home exercise program, 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 - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: improve hand coordination

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

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

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/30/2026