Home Health Certification and Plan of Care

Order ID: 1150/19146

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
AA00005776	05/15/2026	From: 05/15/2026 To: 07/13/2026	25722	217058

6. Patient's Name and Address
Carolyn Stevenson
3233 Belmont Ave,
Batimore, MD 21216-
443-490-9222

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 07/10/1948 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.89	Encounter for other orthopedic aftercare	05/15/26

13. ICD	Other Pertinent Diagnoses	Date
M50.93	Cervical disc disorder unspecified cervicothoracic region	05/15/26
I10.	Essential (primary) hypertension	05/15/26
F32.A	Depression unspecified	05/15/26
D50.9	Iron deficiency anemia unspecified	05/15/26
G62.9	Polyneuropathy unspecified	05/15/26
G43.909	Migraine unsp not intractable without status migrainosus	05/15/26
G47.00	Insomnia unspecified	05/15/26
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	05/15/26
M19.90	Unspecified osteoarthritis unspecified site	05/15/26
E55.9	Vitamin D deficiency unspecified	05/15/26
Z87.891	Personal history of nicotine dependence	05/15/26
Z90.49	Acquired absence of other specified parts of digestive tract	05/15/26
Z90.710	Acquired absence of both cervix and uterus	05/15/26

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

ATENOLOL 100 mg 100 mg / 1 Tablet by mouth once a day for hypertension
Bupropion Hydrochloride - Bupropion Hydrochloride Extended Release 24 Hour 150 mg tablet by mouth once a day for depression
GABAPENTIN 300 mg 300 mg capsule by mouth twice a day for nerve pain
Nifedipine Er - Nifedipine 60 mg 60 mg / 1 Tablet by mouth once a day for hypertension
Trazodone Hydrochloride - Trazodone Hydrochloride 150 mg / 1 Tablet by mouth at bedtime for insomnia
Lidocaine Patch - Lidocaine 4% / Apply to Left shoulder topical once a day for pain and remove per schedule

14. DME and Supplies:
None of the above, , , ,

15. Safety Measures:
bathroom safety, , fall precautions, medication safety, , standard precautions, , ambulates with device

16. Nutrition:
cardiac diet

17. Allergies:
codeine

18.A. Functional Limitations
Ambulation

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: 3. Often, 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
family/caregiver will be responsible for managing treatment

Homebound status: After undergoing Cervical decompression secondary to cervical myelopathy/cervical stenosis, 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 77-year-old female with a past medical history significant for hypertension and lumbar stenosis status post decompression, recently hospitalized for cervical decompression secondary to cervical myelopathy/cervical stenosis. Prior to surgery, the patient reportedly ambulated without an assistive device; however, she experienced significant pain and demonstrated excessive forward-flexed posture. At the time of assessment, the patient is alert and oriented x3. Skin is warm, dry, and intact. No neck pain was reported during the visit, although the patient did report a headache. The patient also reports continued numbness in the left upper extremity, which has improved since surgery. She resides alone in a two-story home with the bedroom and bathroom located on the first floor; her daughter is currently staying with her to provide support and assistance. The patient requires human assistance when leaving the home and demonstrates impaired functional mobility, decreased strength, balance deficits, and decreased safety with ambulation. Physical therapy evaluation was completed, with bilateral lower-extremity strength assessed at 3/5 by manual muscle testing. The patient requires contact guard assistance for transfers and short-distance ambulation with a rolling walker. Occupational therapy noted that the patient has also been ambulating without a device at times; however, due to unsteadiness and safety concerns, use of the walker was recommended. The patient is currently using cervical bracing following surgery. She has been wearing a Miami J/rigid cervical collar most of the time and removes it briefly for rest breaks as tolerated; updated instructions indicate use of the rigid collar when leaving the home, with use of a soft cervical brace otherwise as directed. The patient has not yet resumed tub transfers or bathing in the tub due to collar use and post-operative precautions. Education was provided and reinforced regarding spinal precautions, cervical collar use, fall prevention, safe functional mobility, and avoidance of keeping the arms overhead during activities of daily living. No <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-5 CE-FMS-medication%20list">medication list</mh>, medication changes, or vital sign values were included in the provided assessment notes. The patient would benefit from continued skilled physical therapy services to improve lower-extremity strength, balance, transfer ability, gait safety, endurance, and overall independence with functional mobility in order to return toward prior level of function. She would also benefit from skilled occupational therapy every other week for ADL training, therapeutic exercise, home exercise program instruction, functional mobility training, and safety training. The plan of care includes continued monitoring of post-operative status, reinforcement of cervical/spinal precautions, progression of safe mobility and ADL participation as tolerated, use of recommended assistive device for ambulation, caregiver education as appropriate, and follow-up with the surgeon/provider in approximately two weeks.
 Date of Order 05/15/2026 Orders Physician Face-to-Face Date: 05/04/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Cervical decompression secondary to cervical myelopathy/cervical stenosis 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 <span

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/15/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Edna Baffoe-Bonnie
7900 Oak Point Ct
Pasadena, MD 21122
PHONE: 4438701237 FAX: 14432961684 NPI: 1982117388

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 : 05/04/2026

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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style="font-size: 14px;">Baffoe-Bonnie, Edna

SN Careplans

SN WK1: 1 (05/15/26-05/16/26) ,WK2: 1 (05/17/26-05/23/26) ,WK3: 1 (05/24/26-05/30/26) ,WK4: 1 (05/31/26-06/06/26) ,WK5: 1 (06/07/26-06/13/26) ,WK6: 1 (06/14/26-06/20/26) ,WK7: 1 (06/21/26-06/27/26) ,WK8: 1 (06/28/26-06/30/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100, 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: 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: D0160 - Depression, M2020 - Oral Med Management, D0700 - Social Isolation, M1400 - Dyspnea, constipation, headache, Pain Effect on Sleep, Pain Interference with ADLs, B1000 - Vision Deficit, loss of appetite

PROCEDURES: coordinate/arrange long-term socialization activities

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule

SN Goals

PATIENT-STATED GOAL: Get well andbe able to walk;Get well and be able to get out the house and walk;Get well and be able to get out the house 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
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

PT Careplans

PT WK2: 1 (05/17/26-05/23/26) ,WK4: 1 (05/31/26-06/06/26) ,WK6: 1 (06/14/26-06/20/26) ,WK8: 1 (06/28/26-06/30/26)

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

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal

PT Goals

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

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

Walk 10 Feet - 04. Supervision or touching assistance

Signature of Physician:

Date

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

Date
05/15/2026

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squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed. Upgrade as tolerated, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: 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, 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

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 WK2: 1 (05/17/26-05/23/26) ,WK4: 1 (05/31/26-06/06/26) ,WK6: 1 (06/14/26-06/20/26) ,WK8: 1 (06/28/26-06/30/26)

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: cough/deep breathing exercises, home exercise program: 16 oz water bottle: bilateral shoulder flex to 90 degrees, chest presses, horizontal abd/add, bicep curls 2x10 reps., equipment training, work simplification/energy conservation, transfers training: tub

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 not need help anymore

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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/15/2026