

Home Health Certification and Plan of Care				Order ID: 1150/19208	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
15322172820		06/03/2026		From: 06/03/2026 To: 08/01/2026	
				4. Medical Record No.	
				26340	
				5. Provider No.	
				217058	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Charles Porter			HomeCentris Healthcare LLC		
5001 Raintree Way Apt D,			10 Crossroads Drive, Suite 102		
Baltimore, MD 21206-			Owings Mills, MD 21117-8284		
443-953-0533			410-321-8448		
			1487113239		
8. DOB			9. Sex		
11/21/1982			Male		
11. ICD			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
126.99			Amlodipine Besylate - Amlodipine Besylate 5 mg / 1 Tablet by mouth in the morning for htn		
Other pulmonary embolism without acute cor pulmonale			Nortriptyline Hydrochloride - Nortriptyline Hydrochloride 50 mg / 1 Capsule by mouth once a day for MDD		
06/03/26			Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg / 1 Tablet by mouth every 6 hours as needed for pain		
13. ICD			Polyethylene Glycol 3350 - Polyethylene Glycol 3350 Powder / Give 17 gram by mouth once a day for Bowel Regimen Dissolve in 8oz of water; hold for loose stools		
Other Pertinent Diagnoses			PREGABALIN 100 MG mg mouth every 8 hours for pain		
Date			TYLENOL 500 MG tablets (1,000 mg total) Oral every 8 (eight) hours		
M54.41			ELIQUIS 5 MG tablet (5 mg total) Oral 2 (two) times daily		
Lumbago with sciatica right side			SENOKOT 8.6 MG tablets Oral 2 (two) times daily		
M54.42					
Lumbago with sciatica left side					
G89.29					
Other chronic pain					
I10.					
Essential (primary) hypertension					
E78.5					
Hyperlipidemia unspecified					
L89.329					
Pressure ulcer of left buttock unspecified stage					
I71.20					
Thoracic aortic aneurysm without rupture unspecified					
L30.4					
Erythema intertrigo					
H53.8					
Other visual disturbances					
K59.00					
Constipation unspecified					
E66.813					
Other obesity					
Z68.43					
Body mass index [BMI] 50.0-59.9 adult					
Z79.01					
Long term (current) use of anticoagulants					
Z86.19					
Personal history of other infectious and parasitic diseases					
14. DME and Supplies:			15. Safety Measures:		
wheelchair, walker			walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with device, ambulates with assistance, medication safety, wheelchair precautions, standard precautions, fall precautions		
16. Nutrition:			17. Allergies:		
regular			no known allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
Endurance, Ambulation			Walker, Wheelchair, 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: Yes					
20. Prognosis: good					
22. A Rehabilitation Potential:			22.B.Discharge Plans		
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.			patient will be responsible for managing treatment		
Homebound status: Due to diagnosis of Other pulmonary embolism without acute cor pulmonale, 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: <p class="MsoNoSpacing">Patient is a 43-year-old male admitted to home health services following discharge from a skilled nursing facility and recent hospitalization for deep vein thrombosis (DVT) and pulmonary embolism (PE), resulting in a significant decline in mobility and functional status. Past medical history includes sciatica, chronic lumbago with sciatica, chronic pain, morbid obesity, hypertension, hyperlipidemia, kidney failure, thoracic aortic aneurysm without rupture, anxiety, adjustment disorder with depressed mood, syncope, and a left buttock ulcer. Patient is alert and oriented 4, with vital signs stable and within normal limits. He lives alone in a basement apartment with four steps and a handrail for exit and currently receives 24-hour aide assistance for activities of daily living, meal preparation, and medication reminders. Bed mobility is labored but independent, while transfers from bed and wheelchair require moderate assistance. Patient ambulates approximately 30 feet with a rollator and contact guard assistance and utilizes a wheelchair for longer distances due to decreased endurance, weakness, chronic pain, impaired balance, and reduced activity tolerance. Assessment revealed significantly limited bilateral hip internal rotation, greater on the left, contributing to difficulty with transfers and positioning. Skin assessment showed no open areas or pressure injuries at this time. Education was provided regarding skin breakdown prevention, pain management strategies, medication adherence, energy conservation, and the importance of reporting worsening symptoms or adverse effects. Patient verbalized understanding of all education provided. Skilled nursing, physical therapy, and occupational therapy services are medically necessary for ongoing assessment, disease and medication management, pain control, strengthening, range-of-motion improvement, balance and mobility training, transfer safety, skin integrity monitoring, and restoration of independence with self-care and functional mobility. Patient remains homebound due to significant effort required to leave the home and a Tinetti score of 8/28. <o:p></o:p></p> <p class="MsoNoSpacing"><o:p> </o:p></p> <p class="MsoNoSpacing">Date of Order<o:p></o:p></p> <p class="MsoNoSpacing">06/03/2026 Order<o:p></o:p></p> <p class="MsoNoSpacing">Physician Face-to-Face Date: 05/19/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Other pulmonary embolism without acute cor pulmonale Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p></p> <p class="MsoNoSpacing"> 1 - SOC - SN Notes:<o:p></o:p></p> <p class="MsoNoSpacing">PT Eval Notes:<o:p></o:p></p> <p class="MsoNoSpacing">OT Eval Notes:<o:p></o:p></p> <p class="MsoNoSpacing">Physician: Baffoe-Bonnie, Edna<p>					
SN Careplans			SN Goals		
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 06/03/2026				25. Date HHA Received Signed P0T	
24. Physician's Name and Address			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.		
Edna Baffoe-Bonnie			F2F date : 05/19/2026		
7900 Oak Point Ct					
Pasadena, MD 21122					
PHONE: 4438701237 FAX: 14432961684 NPI: 1982117388					
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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6. Patient's Name and Address Charles Porter 5001 Raintree Way Apt D, Baltimore, MD 21206- 443-953-0533			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	
SN WK1: 1 (06/03/26-06/06/26) ,WK2: 1 (06/07/26-06/13/26) ,WK3: 1 (06/14/26-06/20/26) ,WK4: 1 (06/21/26-06/27/26) ,WK5: 1 (06/28/26-07/04/26) ,WK6: 1 (07/05/26-07/11/26) ,WK7: 1 (07/12/26-07/18/26) 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: 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:MOLST PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, M1400 - Dyspnea, muscle weakness, limited range of motion, limited strength, limited endurance, muscle spasms, B1000 - Vision Deficit, Pain Interference with ADLs, Pain Effect on Sleep, balance deficit, obesity PROCEDURES: teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired 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, patient's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence			PATIENT-STATED GOAL: Patient stated he would like to regain strength GOALS 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 * how to keep home safe for patient with vision loss including eliminating hazards * enhancing lighting * using mechanical aids 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 self-administers medications as prescribed * recalls related medication(s) purpose, schedule patient's transportation needs are met patient is adequately supervised meal preparation is available to patient for all meals caregiver administers and/or packages medications appropriately caregiver performs medical/rehabilitation treatments with adequate competence	
PT Careplans PT WK1: 1 (06/03/26-06/06/26) ,WK2: 1 (06/07/26-06/13/26) ,WK3: 1 (06/14/26-06/20/26) ,WK4: 1 (06/21/26-06/27/26) ,WK5: 1 (06/28/26-07/04/26) ,WK6: 1 (07/05/26-07/11/26)			PT Goals PATIENT-STATED GOAL: To be able to return to work	
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, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair			GOALS Chair to Bed to Chair - 06. Independent Toilet Transfer - 06. Independent Sit to Stand - 06. Independent	
Signature of Physician:			Date	
			PAGE 2 of 3	
Optional Name/Signature of Nurse/Therapist:			Date	
Electronically Signed by Messick, Charles RN			06/03/2026	

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			1487113239		
PROCEDURES: Family training with caregiver : Transfers, gait and therex., home exercise program: Supine hip flexion, bridging, straight leg raise, hip abduction. Internal rotation with legs extended, prone kne flexion and stretch into Internal rotation. Sitting knee extension and ankle pumps, gait training/stair training, transfers training			Car Transfer - 06. Independent		
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 - 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching 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		
			Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance		
OT Careplans			OT Goals		
OT WK2: 1 (06/07/26-06/13/26) ,WK4: 1 (06/21/26-06/27/26) ,WK6: 1 (07/05/26-07/11/26) ,WK8: 1 (07/19/26-07/25/26)			PATIENT-STATED GOAL: Walk up the stairs		
PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, 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			GOALS		
PROCEDURES: Medication Review : Medication reviewed with patient with all medications in the home, home exercise program: Bilateral UE strengthening of deltoid, biceps and triceps muscles, equipment training, work simplification/energy conservation, strengthening exercises: Skilled OT, transfers training: Skilled OT, assist with bathing: Skilled OT, assist with toilet transferring: Skilled OT, assist with lower body dressing: Skilled OT, assist with upper body dressing: Skilled OT			Shower/Bathe Self - 05. Setup or clean-up assistance		
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			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
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/03/2026