# Home Health Certification and Plan of Care

**Order ID: 1150/21048**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 9YN6G66DV84 | 08/03/2026 | From: 08/03/2026 To: 10/01/2026 | 28522 | 217058 |

**6. Patient's Name and Address**
Melvin Miller
4107 Miller Station Road,
Millers, MD 21102-
443-375-0253

**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** 04/12/1949 | **9.Sex** Male

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| F41.9 | Anxiety disorder unspecified | 08/03/26 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| S71.001A | Unspecified open wound right hip initial encounter | 08/03/26 |
| M54.50 | Low back pain unspecified | 08/03/26 |
| G89.4 | Chronic pain syndrome | 08/03/26 |
| I10. | Essential (primary) hypertension | 08/03/26 |
| E55.9 | Vitamin D deficiency unspecified | 08/03/26 |
| G47.00 | Insomnia unspecified | 08/03/26 |
| E78.5 | Hyperlipidemia unspecified | 08/03/26 |
| Z74.01 | Bed confinement status | 08/03/26 |
| Z99.3 | Dependence on wheelchair | 08/03/26 |
| Z79.01 | Long term (current) use of anticoagulants | 08/03/26 |
| Z79.891 | Long term (current) use of opiate analgesic | 08/03/26 |

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

ROSUVASTATIN CALCIUM 5 mg 5 MG Tablet Oral once a day
Metoprolol Tartrate - Metoprolol Tartrate 25 MG Tablet Oral once a day
LYRICA 25 MG Capsule Oral twice a day for nerve pain
LASIX 40 MG Tablet Oral once a day for fluid
Oxycodone Hydrochloride - Oxycodone Hydrochloride 15 MG Tablet Oral every 6 hours as needed for pain
ELIQUIS 5 MG Tablet Oral twice a day
CLONAZEPAM 1 MG Tablet Oral twice a day

**14. DME and Supplies:**
wound care supplies, hospital bed, wheelchair

**15. Safety Measures:**
bathroom safety, bedrails up while in bed, smoke detectors , hand rails, fall precautions, bleeding precautions, ambulates with device, transfer with assist, supervision at all times, emergency phone number prominently displayed, ambulates with assistance, , anticoagulant precautions, activity supervision, standard precautions, medication safety, wheelchair precautions

**16. Nutrition:**
Z. NO PHYSICIAN-ORDERED DIET

**17. Allergies:**
no known allergies

**18.A. Functional Limitations**
Bowel/Bladder Incontinence, Ambulation, Endurance

**18.B. Activities Permitted**
Exercises Prescribed, Transfer bed/Chair, Up As Tolerated

**19. Mental & Psychosocial 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**
family/caregiver will be responsible for managing treatment

**Homebound status:**
Due to diagnosis of Anxiety disorder unspecified, 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 male with a significant past medical history of chronic low back pain, severe chronic pain syndrome, chronic immobility, morbid obesity, chronic right hip wound, chronic left lower-extremity edema, urinary incontinence, anxiety, and a history of bowel obstruction. He was referred for skilled home health physical therapy evaluation due to profound functional decline, chronic immobility, dependence with transfers, and the need for mobility assessment and equipment management. The patient presents with bilateral lower-extremity weakness, impaired bed mobility, inability to safely perform transfers without extensive assistance, and complete loss of functional ambulation, requiring a power wheelchair for primary mobility. He demonstrates significant difficulty with bed repositioning and requires caregiver assistance with activities of daily living and bed mobility, placing him at increased risk for pressure injuries, caregiver burden, and further functional decline. His current air-pressure mattress is reportedly malfunctioning, limiting effective pressure relief, and his power wheelchair is outdated and requires reassessment to safely meet his mobility needs. Arrangements have been made with Austin Pharmacy to facilitate updates to his wheelchair and hospital bed. Skilled home health PT is medically necessary to address strength deficits, bed mobility, transfer training, caregiver education, pressure-relief positioning, seating and mobility assessment, equipment recommendations, safety training, and development of an individualized home exercise program to maximize functional independence, reduce caregiver burden, prevent further skin breakdown, and decrease the risk of hospitalization.<o:p></o:p>    Date of Order<o:p></o:p> 08/03/2026<o:p></o:p> Physician Face-to-Face Date:

**23. Signature and Date of Verbal SOC Where Applicable:**
Electronically Signed by Messick, Charles RN on 08/03/2026

**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 : 07/17/2026

**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.

# Home Health Certification and Plan of Care

**Order ID: 1150/21048**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 9YN6G66DV84 | 08/03/2026 | From: 08/03/2026 To: 10/01/2026 | 28522 | 217058 |

| 6. Patient's Name and Address | 7. Provider's Name, Address and Telephone Number |
|---|---|
| Melvin Miller<br>4107 Miller Station Road,<br>Millers, MD 21102-<br>443-375-0253 | HomeCentris Healthcare LLC<br>10 Crossroads Drive, Suite 102<br>Owings Mills, MD 21117-8284<br>410-321-8448<br>1487113239 |

07/17/2026<span style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman';
font-size:11.0000pt;mso-font-kerning:1.0000pt;"><o:p></o:p> <span
style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman'; font-size:11.0000pt;mso-font-kerning:1.0000pt;">Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat OT-eval & treat dx: Anxiety disorder unspecified<span
style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman';
font-size:11.0000pt;mso-font-kerning:1.0000pt;"><o:p></o:p> <span
style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman'; font-size:11.0000pt;mso-font-kerning:1.0000pt;">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="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman';
font-size:11.0000pt;mso-font-kerning:1.0000pt;"><o:p></o:p> <span
style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman'; font-size:11.0000pt;mso-font-kerning:1.0000pt;">  1 - SOC - PT Notes: <span style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman';
font-size:11.0000pt;mso-font-kerning:1.0000pt;">Physician:<span style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman';
font-size:11.0000pt;mso-font-kerning:1.0000pt;"> Baffoe-Bonnie, Edna

| SN Careplans | SN Goals |
|---|---|
| | |

| PT Careplans | PT Goals |
|---|---|
| PT WK1: 2 (08/03/26-08/08/26) ,WK2: 1 (08/09/26-08/15/26) ,WK3: 1 (08/16/26-08/22/26) ,WK4: 1 (08/23/26-08/29/26) | PATIENT-STATED GOAL: to have the wheelchair and bed updated |
| 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 | GOALS<br>patient/caregiver recalls<br>* lifestyle modifications to manage respiratory condition including<br>* diet changes and regular exercise<br>* strategies to control shortness of breath<br>* home remedies to keep lungs healthy<br>* recalls related medication(s) purpose, schedule |
| CAREGIVER: 0. No assistance needed - patient is independent or does not have needs in this area | |
| HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion | patient/caregiver recalls<br>* how to achieve wound healing including cleaning and dressing wound<br>* position changes<br>* skin care<br>* diet modification<br>* record wound measurements<br>* recalls related medication(s) purpose, schedule |
| 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.<br>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.<br>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<br>Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.<br>Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.<br>Provide education content at patient's level of health literacy.<br>Assess/Instruct Pt/Pcg: Safety measures to prevent injury.<br>Assess: Musculoskeletal status.<br>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<br>Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.<br>Pt/Pcg educated in pain management techniques including positioning and relaxation techniques<br>Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.<br>Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training<br>Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.<br><br>; 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, | patient/caregiver recalls<br>* strategies to minimize fatigue and exhaustion including work simplification<br>* energy conservation<br>* lifestyle changes<br>* diet<br>* recalls related medication(s) purpose, schedule<br><br>patient self-administers medications as prescribed<br>* recalls related medication(s) purpose, schedule<br><br>Chair to Bed to Chair - 02. Substantial/maximal assistance<br><br>Car Transfer - 02. Substantial/maximal assistance<br><br>Sit to Stand - 02. Substantial/maximal assistance<br><br>Wheel 50 ft w 2 Turns - 06. Independent<br><br>Wheel 150 feet - 06. Independent<br><br>Oral Hygiene - 03. Partial/moderate assistance<br><br>Shower/Bathe Self - 02. Substantial/maximal assistance<br><br>Upper Body Dressing - 03. Partial/moderate assistance<br><br>Eating - 05. Setup or clean-up assistance<br><br>Toilet Transfer - 01. Dependent<br><br>Toileting Hygiene - 01. Dependent<br><br>Lower Body Dressing - 01. Dependent |

| Signature of Physician: | Date |
|---|---|
| | PAGE 2 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 08/03/2026 |

# Home Health Certification and Plan of Care

**Order ID: 1150/21048**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 9YN6G66DV84 | 08/03/2026 | From: 08/03/2026 To: 10/01/2026 | 28522 | 217058 |

| 6. Patient's Name and Address | 7. Provider's Name, Address and Telephone Number |
|---|---|
| Melvin Miller<br>4107 Miller Station Road,<br>Millers, MD 21102-<br>443-375-0253 | HomeCentris Healthcare LLC<br>10 Crossroads Drive, Suite 102<br>Owings Mills, MD 21117-8284<br>410-321-8448<br>1487113239 |

dose, interactions of all new/change meds
Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170R1 - Wheel 50 ft w 2 Turns, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170S1 - Wheel 150 feet, GG0170F1 - Toilet Transfer, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, limited strength, muscle weakness, limited endurance, daytime fatigue, balance deficit, pain radiating to arms/legs, #1 - Other - Anterior Right Hip -

PROCEDURES: physician-ordered wound care: #1 - Other - Anterior Right Hip -: managed by wound care center, home exercise program: Instructed patient and caregiver in a home exercise program consisting of active/active-assisted lower extremity range of motion, ankle pumps, quad sets, gluteal sets, and gentle upper/lower extremity exercises as tolerated. Reinforced frequent pressure-relief weight shifts, bed repositioning every 2 hours, deep breathing exercises, and daily performance within pain tolerance to maintain circulation, joint mobility, strength, and skin integrity while reducing complications associated with prolonged immobility., equipment training, transfers training

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 achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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, Chair to Bed to Chair - 02. Substantial/maximal assistance, Car Transfer - 02. Substantial/maximal assistance, Sit to Stand - 02. Substantial/maximal assistance, Toilet Transfer - 01. Dependent, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, Oral Hygiene - 03. Partial/moderate assistance, Toileting Hygiene - 01. Dependent, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 03. Partial/moderate assistance, Lower Body Dressing - 01. Dependent, Don/Doff Footwear - 01. Dependent, Eating - 05. Setup or clean-up assistance

Don/Doff Footwear - 01. Dependent

| Signature of Physician: | Date |
|---|---|
| | PAGE 3 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 08/03/2026 |