HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022096

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
57234499	09/14/2026	09/14/2026 - 11/12/2026	30044	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Hanaa Hussein 6691HAWKEYE RUN COLUMBIA, MD 21044	Female	10/21/1973	443-546-5484
	Email		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI: 1487113239		Fax Number: 410-559-3002

Clinical Condition Requiring Homecare:

The patient is a 54-year-old female status post spinal surgery secondary to acquired lumbosacral spondylolisthesis, specifically L5-S1 posterior decompression and fusion with instrumentation. Past medical history includes hypertension (HTN), gastroesophageal reflux disease (GERD), headaches, hyperlipidemia (HLD), hypothyroidism, dizziness/presyncope, and dysuria. The patient also reports a history of brain aneurysm for which she underwent surgical intervention. The patient reports a history of back pain for approximately 20 years and currently experiences postoperative back pain rated 8/10, difficulty bending, right lower extremity radiating pain, and numbness in both feet. The patient is taking oxycodone for pain management and is receiving Lovenox SQ injections following surgery. She denies shortness of breath, and lungs are clear throughout. The patient reports a good appetite and last bowel movement was today. The lower back incision measures 11.5 cm in length, is open to air, and shows no signs or symptoms of infection. A walker is available in the home for safe ambulation. The patient resides with her two sons and one daughter in a two-level single-family home. Prior to surgery, the patient was independent with functional activities and mobility; she remains able to complete BADLs but is currently limited by postoperative pain and requires rest breaks and AD devices to complete tasks safely. The patient has been instructed not to bend following spinal surgery. Skilled nursing frequency is 1W4, with PT/OT evaluation ordered. Skilled nursing reviewed all medications and provided education regarding signs and symptoms of bleeding, Lovenox SQ injection administration and SQ injection sites, proper sharps disposal, effective pain management, and closed incision line care. The patient was receptive to all instructions provided. Skilled OT intervention is required to address functional limitations, improve independence with ADLs, improve UE strengthening, promote safe use of AD devices, and improve quality of life, with the patient's stated goal of returning to her prior level of function without pain. The

Physician Statement on Homebound Status:

After undergoing Spinal surgery secondary to acquired lumbosacral spondylolisthesis, specifically l5-s1 posterior decompression and fusion with instrumentation, 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.

plan of care will continue with skilled nursing follow-up, medication and postoperative monitoring, pain and incision management, safety education, and PT/OT services as ordered.

Date of Order
09/14/2026
Orders
Physician Face-to-Face Date: 09/05/2026
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Spinal surgery secondary to acquired lumbosacral spondylolisthesis, specifically l5-s1 posterior decompression and fusion with instrumentation
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
PT Eval Notes:

Physician
Ambati, Madhavi

ICD-10 CM Principal Diagnosis: Z47.89. Encounter for other orthopedic aftercare

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
M43.17	Spondylolisthesis lumbosacral region	Metformin Er - Metformin Hydrochloride 500MG; 1 TAB by mouth in the evening DM Darifenacin - Darifenacin Hydrobromide 7.5 MG; 1 TAB by mouth once a day OVERACTIVE BLADDER Famotidine - Famotidine 40 mg 40MG; 1 TAB by mouth once a day STOMACH ENOXAPARIN SODIUM 30 mg subcutaneous q12h SCH BLOOD THINNER Lisinopril - Lisinopril 10 mg 10MG; 1 TAB by mouth once a day BLOOD PRESSURE ATORVASTATIN 10 mg oral Daily CHOLESTEROL PANTOPRAZOLE 40 mg 40 mg oral Daily STOMACH PREGABALIN 150 mg oral BID PAIN LEVOTHYROXINE 125 MCG; 1 TAB oral Daily THYROID Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5MG; 1 TAB by mouth every 4 hours PAIN sennosides-docusate sodium 1 tablet oral BID BOWEL REGIMEN iron-vitamin C 1 tablet oral Daily SUPPLEMENT
I10.	Essential (primary) hypertension	
E78.5	Hyperlipidemia unspecified	
K21.9	Gastro-esophageal reflux disease without esophagitis	
E03.9	Hypothyroidism unspecified	
R51.9	Headache unspecified	
Z98.1	Arthrodesis status	
Z79.01	Long term (current) use of anticoagulants	
Z79.4	Long term (current) use of insulin	
Z79.891	Long term (current) use of opiate analgesic	

Prognosis
fair

Mental and 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

Functional Limitations
Ambulation, Endurance

Activities Permitted
Walker, Exercises Prescribed, Up As Tolerated

DME & Supplies
walker

Safety Measures
smoke detectors , emergency phone # clearly displayed, ambulates with assistance, bathroom safety, supervision at all times, transfer with assist, standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, sharps precautions, anticoagulant precautions, activity supervision

Nutrition
low cholesterol, low sodium

Allergies
amoxicillin

sumatriptan

Advance Directives
No Advance Directive

Caregiver Status
2. Non-agency caregiver(s) need training/supportive services to provide assistance; 2. Non-agency caregiver(s) need training/supportive services to provide assistance

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.

DISCHARGE PLAN:
SN: family/caregiver will be responsible for managing treatment
OT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

OT Eval

SN CAREPLAN

SN frequency WK1: 1 (09/14/26-09/19/26),WK2: 2 (09/20/26-09/26/26),WK3: 2 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26),WK6: 1 (10/18/26-10/24/26),WK7: 1 (10/25/26-10/31/26)

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, 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

09/16/2026 Problems : muscle weakness (MS)
#1 - Observable Surgical Wound - Other - LOWER BACK CLOSED SURGICAL INCISION - INSICION OPEN TO AIR
M1600 - UTI
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with ADLs

SN NARRATIVE

PATIENT S/P BACK SURGERY D/T ACQUIRED LUMBOSACRAL SPONDYLOLISTHESIS. PMH INCLUDES HTN, GERD, HEADACHES, HLD AND HYPOTHYROIDISM. SN FREQ 1W4; PT/OT EVAL ORDERED.

PATIENT ALERT AND ORIENTED X3, REPORTS BACK PAIN AS 8/10, TAKING OXYCODONE FOR PAIN, DENIES SOB, LUNGS CLEAR THROUGHOUT, REPORTS GOOD APPETITE, LBM TODAY, PT LOWER BACK INCISION MEASURES 11.5 CM IN LENGTH, OPEN TO AIR, NO S/S OF INFECTION ; WALKER IN THE HOME FOR SAFE AMBULATION.

SN REVIEWED ALL MEDICATIONS, S/S OF BLEEDING, PT ON LOVENOX SQ INJECTION, SQ INJECTION SITES, SHARPS DISPOSAL, EFFECTIVE PAIN MANAGEMENT, CLOSED INCISION LINE CARE. PT RECEPTIVE TO ALL INSTRUCTIONS.

SN GOALS

PATIENT-STATED GOAL: FOR BACK PAIN TO GET BETTER

GOALS
patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

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
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

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

M1400 - Dyspnea
M2020 - Oral Med Management
balance deficit
limited range of motion
limited strength
limited endurance
meal preparation
M2102d - Caregiver Performs Treatment
M2102f - Patient Supervision
M2102c - Med Admin

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - LOWER BACK CLOSED SURGICAL INCISION - INSICION OPEN TO AIR: OPEN TO AIR, cough/deep breathing exercises, 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately

OT CAREPLAN

OT frequency WK1: 1 (09/14/26-09/19/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26),WK6: 1 (10/18/26-10/24/26),WK7: 1 (10/25/26-10/31/26)

09/17/2026 Problems : GG0170N1 - 4 Steps
GG0130F1 - Upper Body Dressing
GG0130A1 - Eating
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene
GG0170E1 - Chair to Bed to Chair
GG0170P1 - Picking Up Object
GG0170O1 - 12 Steps
Pain Effect on Sleep
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
GG0170F1 - Toilet Transfer
GG0170D1 - Sit to Stand
M1400 - Dyspnea
Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises, incentive spirometer, home exercise program: bending, deep breaths, shoulder and elbow exercises, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair 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 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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, 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 NARRATIVE

Pt is a 54 yo female, with hx of spndilolithesis of lumbosacral, pmhx of HTN, GERD, headaches, HLD, hypothyroidism, s/p spinal sx L5-S1 posterior decompression and fusion with instrutmentation, dizziness presyncope, dysuria, HTN, hypothyrodism. Pt is a post op spinal sx, complains of still pain, difficulty bending, rt le radiating pain, numbness in both feet. Pt lives with her 2 sons and 1 daughter in a single family house with 2 levels. Pt has back pain since 20 years. Pt takes blood thinner shot after sx. According to the Pt she had brain aneurysm and was operated for it. Pt is asked not to bend after spinal sx. Pt was I in her PLOF and currently is but limited due to pain. Pt is able to complete her BADLs with breaks due to pain. Pt needs AD devices to complete a task. Pt wants to return to PLOF with no pain. SKilled OT inervention is reqruied to gain I, improve UE strengthening, improve QOL.

OT GOALS

PATIENT-STATED GOAL: retunr to PLOF, wants to be able to bend

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

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

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 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 and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/14/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services. F2F date: 09/05/2026	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.
Certifying Physician or Allowed Practitioner Name and Address **Madhavi Ambati** 7070 Samuel Morse Dr Columbia, MD 21046 NPI 1396056297	**Phone Number** 800-777-7904 **Fax Number** 18554141694

Physician's Signature and Date Signed

X

Madhavi Ambati, MD
09/05/2026: Date of physician last face-to-face