Home Health Certification and Plan of Care

Order ID: 1150/12025

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
87125932	08/27/2025	From: 08/27/2025 To: 10/25/2025	16785	217058

6. Patient's Name and Address
Lillian Hoyle
12820 Eastern Ave,
MIDDLE RIVER, MD 21220-
443-413-1087

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 01/17/1929 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S72.491D	Oth fx lower end of r femur subs for clos fx w routn heal	08/27/25

13. ICD	Other Pertinent Diagnoses	Date
E78.5	Hyperlipidemia unspecified	08/27/25
N18.9	Chronic kidney disease u	08/27/25
D63.1	Anemia in chronic kidney disease	08/27/25
I48.91	Unspecified atrial fibrillation	08/27/25
G30.9	Alzheimer's disease unspecified	08/27/25
F02.84	Dem in other dis classd elswhr unsp severity with anxiety	08/27/25
E53.8	Deficiency of other specified B group vitamins	08/27/25
M19.90	Unspecified osteoarthritis unspecified site	08/27/25
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	08/27/25
Z91.81	History of falling	08/27/25

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

acetaminophen (TYLENOL 8 HOUR ARTHRITIS PAIN) 650 mg , take capsule by mouth every 6 hours 650 mg, every 6 hours PRN Pain
iron-vitamin C (VITRON-C) 65-125 MG TABS 65-125 MG , take 1 tablet by mouth three times per week 1 tablet, three times per week. Supplement
Lipitor - Atorvastatin Calcium 20 mg , take 20 mg tablet by mouth at bedtime 20 mg, nightly Cholesterol
Zoloft - Sertraline Hydrochloride 100 mg, take 100 mg tablet by mouth once a day 100 mg, 1 time daily Depression
Melatonin - Melatonin 6 mg, take 2 tablets by mouth at bedtime 6 mg, Oral, nightly PRN, (2 tablets) Insomnia

14. DME and Supplies:
wheelchair, grab bars, hoyer lift, commode, hospital bed

15. Safety Measures:
wheelchair precautions, standard precautions, fall precautions, bedrails up while in bed, non-weight bearing RLE, transfer with assist

16. Nutrition:
regular

17. Allergies:
cipro pcn sulfa antibiotics

18.A. Functional Limitations
Contracture, Bowel/Bladder Incontinence, Ambulation

18.B. Activities Permitted
No Restrictions

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions!3. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc., HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans
patient will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status:
Due to diagnosis of Other Fracture Of The Lower End Of The Right Femur, Specifically A Subsequent Encounter For A Closed Fracture With Routine Healing, 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 96-year-old woman with a significant past medical history including dementia, anxiety, and a displaced segmental fracture of the shaft of the right femur following an unwitnessed fall at her assisted living facility. She was recently hospitalized for fracture management and currently has her right leg immobilized in a cast secured with an ace bandage. She is non-weight-bearing on the right lower extremity and, per her daughter, has been wheelchair-bound for the past two years. The patient is oriented only to self and demonstrates confusion, difficulty following directions, and limited ability to answer simple questions. She denies pain at rest but experiences discomfort with movement. On assessment, the patient was found to be bedbound and dependent on caregivers for bathing, toileting, transfers, bed mobility, and lower-body dressing, requiring maximal assistance for upper-body dressing tasks. Transfers are performed using a Hoyer lift. The left knee demonstrates a flexion deformity due to hamstring tightness and restriction. Gentle passive range-of-motion stretching was performed to the right knee, hip, and ankle, followed by repositioning in bed. Caregivers were educated on the importance of repositioning the patient at least every two hours, ensuring meticulous incontinence care, and applying zinc oxide paste to protect skin integrity and prevent pressure-related injury. Examination revealed intact skin overall; however, redness and excoriation were noted over the sacrum. Pulmonary assessment revealed clear breath sounds bilaterally, with even and unlabored respirations. Cardiovascular status remained stable with vital signs within normal limits. Abdominal examination showed an abdomen that was soft, non-tender, with active bowel sounds in all quadrants. No edema was observed. The patient is scheduled for a postoperative orthopedic follow-up on 9/2/2025. The family and caregivers were instructed to keep the patient primarily in bed until she is formally assessed by physical therapy. At this time, the patient is not appropriate for ongoing occupational therapy services beyond evaluation, given her cognitive status, dependence in ADLs, and non-weight-bearing restrictions. The plan of care will focus on caregiver education, prevention of skin breakdown, safe positioning, maintenance of joint mobility through passive range-of-motion, and coordination with physical therapy and orthopedic services to guide rehabilitation potential.
 Date of Order 08/27/2025 Orders Physician Face-to-Face Date: 08/15/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat due to Other Fracture Of The Lower End Of The Right Femur, Specifically A Subsequent Encounter For A Closed Fracture With Routine Healing 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: PT Eval Notes: OT Eval Notes: Physician Mathur, Rita

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 08/27/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Rita Mathur
4920 Campbell Blvd
White Marsh, MD 21236
PHONE: 410-933-7793 FAX: 14109337666 NPI: 1619076338

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 : 08/15/2025

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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SN Careplans

SN WK1: 1 (08/27/25-08/30/25) ,WK2: 1 (08/31/25-09/06/25) ,WK3: 1 (09/07/25-09/13/25) ,WK4: 1 (09/14/25-09/20/25) ,WK5: 1 (09/21/25-09/27/25)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M1745 - Behavioral Issues, D0160 - Depression, M1700 - Cognition, M2020 - Oral Med Management, abn cholesterol > 200 mg/dL, M1400 - Dyspnea, M1620 - Bowel Incontinence, frequent urination, M1610 - Urinary Incontinence, limited range of motion, Pain Interference with ADLs, Pain Effect on Sleep, balance deficit, loss of appetite, swell/redness surround. skin, #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Anterior Right Hip - Cleanse wound with NSS, pat dry, apply medhoney, cover with bordered gauze , #2 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Left Heel - Cleanse with NSS, pat dry, apply medhoney, cover with bordered gauze.

PROCEDURES: physician-ordered wound care, monitor intake & output, bladder training

09/12/2025. Physician ordered wound care to Left heel, Notes: 09/12/2024 Discontinue all previous wound care orders to left heel ----------Skill nurse/family/caregiver to cleanse wound on left heel with normal saline, apply betadine, let dry then apply Medi honey and cover with foam dressing. Change every 2-3 days and PRN if soiled or wet., Physician ordered wound care to right hip, Notes: 09/12/2025 Discontinue all previous wound care orders to right hip.----------New order - cleanse wound to right hip with wound spray, apply Silver Alginate to wound bed, cover with border foam dressing. Change every 2-3 days and PRN if soiled or wet.,

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, * low cholesterol dietary guidelines, 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants,

SN Goals

PATIENT-STATED GOAL: To be able to transfer safely from the bed to the wheelchair.

GOALS
patient/caregiver recalls
* pain control
* therapeutic exercises to optimize range of motion of affected area
* diet and fluids to promote healing
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* low cholesterol dietary guidelines
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet
* exercise
* monitoring of blood pressure
* blood sugar
* home
* recalls related medication(s) purpose, schedule remedies

patient/caregiver recalls
* how to manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* 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
* 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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	08/27/2025

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conflicts, and threats, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet exercise monitoring of blood pressure blood sugar home, related medication(s) purpose, schedule remedies, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, 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, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * how to manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, related medication(s) purpose, schedule, * pain control therapeutic exercises to optimize range of motion of affected area diet and fluids to promote healing, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

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
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* recalls related medication(s) purpose, schedule

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

PT Careplans

PT WK1: 1 (08/27/25-08/30/25) ,WK2: 1 (08/31/25-09/06/25) ,WK3: 1 (09/07/25-09/13/25) ,WK4: 1 (09/14/25-09/20/25) ,WK5: 1 (09/21/25-09/27/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet

PROCEDURES: Medication review: No issue was reported , cough/deep breathing exercises, incentive spirometer, wheelchair 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, Sit to Stand - 03. Partial/moderate assistance, Chair to Bed to Chair - 03. Partial/moderate assistance, Toilet Transfer - 04. Supervision or touching assistance, Car Transfer - 03. Partial/moderate assistance, Wheel 50 ft w 2 Turns - 01. Dependent, Wheel 150 feet - 01. Dependent

PT Goals

PATIENT-STATED GOAL: The caregiver wants the patient to be able to pivot when assisted to transer from bed and sit in the wheelchair

GOALS
Sit to Stand - 03. Partial/moderate assistance

Chair to Bed to Chair - 03. Partial/moderate assistance

Toilet Transfer - 04. Supervision or touching assistance

Car Transfer - 03. Partial/moderate 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

Wheel 50 ft w 2 Turns - 01. Dependent

Wheel 150 feet - 01. Dependent

OT Careplans

OT WK1: 6 (08/27/25-08/30/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

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, Oral Hygiene - 06. Independent, Upper Body Dressing - 03. Partial/moderate assistance, Lower Body Dressing - 01. Dependent, Shower/Bathe Self - 01. Dependent, Toileting Hygiene - 01. Dependent, Don/Doff Footwear - 01. Dependent, Eating - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: Eval only

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

Oral Hygiene - 06. Independent

Upper Body Dressing - 03. Partial/moderate assistance

Lower Body Dressing - 01. Dependent

Shower/Bathe Self - 01. Dependent

Toileting Hygiene - 01. Dependent

Don/Doff Footwear - 01. Dependent

Eating - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	08/27/2025