Home Health Certification and Plan of Care

Order ID: 1150/13213

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
84124551	10/18/2025	From: 10/18/2025 To: 12/15/2025	18510	217058

6. Patient's Name and Address

Sarah Zichos
260 Armstrong Ln,
PASADENA, MD 21122-
443-714-5060

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 03/05/1994 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S52.91XD	Unsp fracture of r forearm subs for clos fx w routn heal	10/18/25

13. ICD	Other Pertinent Diagnoses	Date
S52.201D	Unsp fx shaft of right ulna subs for clos fx w routn heal	10/18/25
S42.031D	Disp fx of lateral end r clavicle subs for fx w routn heal	10/18/25
S72.301D	Unsp fx shaft of right femur subs for clos fx w routn heal	10/18/25
S72.421D	Disp fx of lateral condyle of r femr 7thD	10/18/25
S82.101D	Unsp fx upper end of r tibia subs for clos fx w routn heal	10/18/25
S82.401D	Unsp fx shaft of r fibula subs for clos fx w routn heal	10/18/25
S72.111D	Disp fx of greater trochanter of r femr 7thD	10/18/25
S82.891D	Oth fracture of r low leg subs for clos fx w routn heal	10/18/25
I70.92	Chronic total occlusion of artery of the extremities	10/18/25
S06.820D	Injury of l int carotid intcr w/o LOC subs	10/18/25
S92.201D	Fx unsp tarsal bone(s) of r foot subs for fx w routn heal	10/18/25
S27.321D	Contusion of lung unilateral subsequent encounter	10/18/25
J98.4	Other disorders of lung	10/18/25
S22.41XD	Multiple fx of ribs right side subs for fx w routn heal	10/18/25
T79.7XXD	Traumatic subcutaneous emphysema subsequent encounter	10/18/25
I26.99	Other pulmonary embolism without acute cor pulmonale	10/18/25
J93.83	Other pneumothorax	10/18/25
R33.9	Retention of urine unspecified	10/18/25
Z79.82	Long term (current) use of aspirin	10/18/25
Z79.01	Long term (current) use of anticoagulants	10/18/25

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

Acetaminophen - Acetaminophen 1,000 mg, Tablet by mouth four times a day pain
Aspirin - Aspirin 81 mg, Tablet by mouth once a day prophylactic
Ciprofloxacin - Ciprofloxacin 750mg; 1 tab by mouth twice a day hardware infection
for 8 days
Dabigatran Etexilate - Dabigatran Etexilate 150 mg, Tablet by mouth twice a day blood thinner
Famotidine - Famotidine 20 mg 20mg; 1tab by mouth once a day stomach
Melatonin - Melatonin 10mg; 1 Tablet by mouth at bedtime sleep
Methocarbamol - Methocarbamol 750 mg 750mg; Tablet by mouth three times a day muscle relaxant
Multivitamins - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tablet by mouth once a day supplement
Mupirocin - Mupirocin 1 Application topical once a day on skin graft
Pregabalin - Pregabalin 150 mg, 1 cap by mouth three times a day pain
Senna - Senna 8.6mg; 1 tab inhalant twice a day for bowel regime
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 15mg; 1 tab by mouth every 6 hours as needed for pain

14. DME and Supplies:

commode, wheelchair, sliding board, wound care supplies

15. Safety Measures:

wheelchair precautions, non-weight bearing RLE, , , , transfer with assist, supervision at all times, , activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Exercises Prescribed, Wheelchair

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: No

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

family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Unspecified Fracture Of Right Forearm, Subsequent Encounter For 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 31-year-old female recently admitted to home health services following a motorcycle accident on August 28, 2025, which resulted in multiple traumatic injuries, including fractures of the right foot and ankle, left femur, right elbow, and multiple ribs and the sternum. Her past medical history is notable for pulmonary embolism (PE) and urinary retention. The patient underwent multiple orthopedic surgical repairs and required intravenous antibiotics during hospitalization due to a hardware-associated infection. She remained hospitalized and in rehabilitation from August 28 to October 17, 2025. At present, the patient is alert and oriented 3 and resides with her parents in a multi-level home that has been modified for accessibility, including a wheelchair ramp at the entrance and a bed arranged in the dining room to facilitate first-floor living. She is non-weight-bearing (NWB) on both the right lower extremity (RLE) and right upper extremity (RUE) and follows a dangle protocol for the RLE. The patient currently has an external fixator in place on the R foot. She is permitted to remove her occupational therapy splint during the day to perform full range-of-motion exercises for the right elbow as tolerated. She performs stand-pivot transfers using her left lower extremity with assistance. The RLE surgical site includes a skin graft and free flap, which are cleansed with normal saline, Vashe solution, and warm soap and water per protocol. After cleansing, the area is patted dry, a thin layer of Bactroban ointment is applied, and the site is left open to air. During this visit, the external fixator was observed to be intact, with no signs of drainage or infection. The patient reported pain of 4/10 localized to the RLE, which is effectively managed with prescribed analgesics. She denied shortness of breath, and lung sounds were clear bilaterally. Appetite is good, and she reports a bowel movement today. Skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-visits">visits</mh> are scheduled at a frequency of 1w12w21w1 to monitor wound healing, assess for signs of infection, reinforce NWB and dangle protocol compliance, and provide ongoing education on surgical site care and pain management. Physical and occupational therapy evaluations have been ordered to support mobility, upper extremity function, and activities of daily living (ADLs). The patient's parents assist with all ADLs and instrumental activities of daily living (IADLs). Education was provided regarding wound care procedures, effective pain control, and the importance of adhering to activity restrictions to prevent complications and promote healing. Both the patient and her father verbalized understanding of all teaching and demonstrated appropriate engagement in the care plan. <span style="white-space: pre; white-space:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 10/18/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Sharon Chung
7670 Quarterfield Rd
Glen Bernie, MD 21061
PHONE: 410-508-7650 FAX: 1-410-508-7701 NPI: 1295026045

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 : 10/10/2025

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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normal;">
 Date of Order 10/18/2025 Orders Physician Face-to-Face Date: 10/10/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Unspecified Fracture Of Right Forearm, Subsequent Encounter For 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: soc PT Eval Notes: OT Eval Notes: Physician Chung, Sharon

SN Careplans

SN WK1: 1 (10/18/25-10/18/25) ,WK2: 1 (10/19/25-10/25/25) ,WK3: 2 (10/26/25-11/01/25) ,WK4: 1 (11/02/25-11/08/25)

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: 7. Currently taking 5 or more medications, 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; 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

PROBLEMS IDENTIFIED ON ASSESSMENT: meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, swelling in the arms/legs, dependent edema, limited endurance, muscle spasms, muscle weakness, limited range of motion, swelling of affected area, limited strength, Pain Interference with ADLs, balance deficit, weak hand grips, Pain Interference with Therapy activities, open sores/lesions, discolored patches of skin, #1 - Observable Surgical Wound - Other - Right Lower Leg - FIXATOR AND GRAFT SITE

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: SN/CG TO PERFORM CARE TO RLE SURGICAL SITE: RLE SURGICAL SITE SKIN GRAFT/FREE FLAP CLEANSE WITH NS, VASHE, WARM SOAP AND WATER. PAT DRY THIN LAYER OF BACTROBAN KEEP OPEN TO AIR. DAILY

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * 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, * 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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: TO GET BETTER;TO GET BETTER AND BE ABLE TO WALK AGAIN

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

patient/caregiver recalls
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* 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
* 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

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 2 (10/19/25-10/25/25) ,WK3: 2 (10/26/25-11/01/25) ,WK4: 2 (11/02/25-11/08/25)

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

PROCEDURES: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-L Mini squat, L heel/toe raise, R hip flex, R hip abd, R hip ext, R leg curls., static standing balance exercises: W/c, BSC, transfer board, dynamic standing balance exercises, gait training on uneven surfaces: When given weight bearing clearance for R UR and LE, gait training/stair training When given weight bearing clearance for R UR and LE, transfers training, assist with fall prevention

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 06. Independent, Walk 10 Feet - 03. Partial/moderate assistance, Walk 50 ft with 2 Turns - 03. Partial/moderate assistance, Walk 150 Feet - 03. Partial/moderate assistance, 1 - Step (curb) - 03. Partial/moderate assistance, 4 Steps - 03. Partial/moderate assistance, 12 Steps - 03. Partial/moderate assistance, Picking Up Object - 03. Partial/moderate assistance

PT Goals

PATIENT-STATED GOAL: I want to be able to move again

GOALS
Chair to Bed to Chair - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 03. Partial/moderate assistance

Walk 50 ft with 2 Turns - 03. Partial/moderate assistance

Walk 150 Feet - 03. Partial/moderate assistance

1 - Step (curb) - 03. Partial/moderate assistance

4 Steps - 03. Partial/moderate assistance

12 Steps - 03. Partial/moderate assistance

Picking Up Object - 03. Partial/moderate assistance

Toilet Transfer - 05. Setup or clean-up assistance

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	10/18/2025