Home Health Certification and Plan of Care

Order ID: 1150/12375

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
35901060	09/20/2025	From: 09/20/2025 To: 11/17/2025	17575	217058

6. Patient's Name and Address
Ellen Gross
1722 Wadsworth Way,
BALTIMORE, MD 21239-
443-416-1194

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 01/15/1944 | **9.Sex** Female

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

Furosemide - Furosemide 20 Mg, 1 tablet for fluid by mouth once a day Start Furosemide Tablet, 20 MG, 1 tablet for fluid, Orally, Once a day, 30 days, 30 Tablet, Refills 1

11. ICD	Principal Diagnosis	Date
M80.0AXD	Age-rel osteopor with current path fx other site 7thD	09/20/25

13. ICD	Other Pertinent Diagnoses	Date
N18.31	Chronic kidney disease stage 3a	09/20/25
E03.9	Hypothyroidism unspecified	09/20/25
K21.9	Gastro-esophageal reflux disease without esophagitis	09/20/25
E78.5	Hyperlipidemia unspecified	09/20/25
Z87.891	Personal history of nicotine dependence	09/20/25
Z91.81	History of falling	09/20/25

14. DME and Supplies:
grab bars, bath bench, walker, cane

15. Safety Measures:
transfer with assist, walker precautions, , medical alert/lifeline, , emergency phone # clearly displayed, bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:
regular

17. Allergies:
latex

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

18.B. Activities Permitted
Cane, Walker, 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: No

20. Prognosis: fair

22. A Rehabilitation Potential:
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.

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 Age-Related Osteoporosis With A Current Pathological Fracture At Another Site, 7Thd, With A Subsequent Encounter For 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 an 81-year-old woman referred to home health services following a syncopal episode and two falls within the past 60 days that resulted in a closed fracture of the left pubic/pelvic region currently healing. Her past medical history is significant for chronic kidney disease, hypothyroidism, gastroesophageal reflux disease, and hyperlipidemia. She resides alone in a multilevel row house (bedroom/bath on the 2nd floor) and receives daily assistance/supervision from adult children. On assessment the patient was alert and oriented, skin intact, and reported occasional urinary incontinence. Exam revealed +2 edema of the left lower extremity and trace edema of the right lower extremity; no open wounds were noted. Functionally, she ambulates indoors with a walker using a step-to gait with supervision and verbal cues, requires supervision for bed mobility and transfers, and completed 14 steps with minimal assistance using a partial handrail. Her Tinetti score was 12/28, consistent with high fall risk and homebound status due to the effort required to leave home. The patient tolerated therapeutic activity (10 repetitions each of supine hip flexion, bridging, hook-lying rotation, straight leg raise, hip abduction, knee extension, and ankle pumps) and declined analgesic medication at this time. Interventions and education: PT/OT evaluations were ordered and a home exercise program was reviewed with the patient; skilled nursing follow-up was recommended per agency protocol (SN frequency 1w3) with the next SN visit scheduled Wednesday. Education provided addressed safe ambulation, assisted transfers, fall-prevention strategies, and encouragement to report new or worsening pain, swelling, or changes in continence. Plan of care: begin skilled home physical therapy to improve lower-extremity strength, endurance, balance, stair negotiation and transfer safety; initiate occupational therapy as indicated to address ADL safety and toileting management; continue skilled nursing surveillance for edema, skin integrity, medication review, and care coordination; and reassess mobility, pain control, and discharge needs at the next <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-visits">visits</mh>.
 Date of Order 09/20/2025 Orders Physician Face-to-Face Date: 09/16/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat due to Age-Related Osteoporosis With A Current Pathological Fracture At Another Site, 7Thd, With A Subsequent Encounter For 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 Ramos, Manuel

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 09/20/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Manuel Ramos
1205 York Road Suite 36
Lutherville , MD 21093
PHONE: 4108327350 FAX: 14108327351 NPI: 1427166222

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 : 09/16/2025

27. Attending Physician's Signature and Date Signed **10/16/2025** 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 WK1: 1 (09/20/25-09/20/25)

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), 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months

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: M2020 - Oral Med Management, M1400 - Dyspnea, swelling in the arms/legs, dependent edema, M1610 - Urinary Incontinence, muscle weakness, swelling of affected area, limited range of motion, limited strength

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises

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 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, * how to manage complications of immobility including skin care strength, balance dexterity and range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing and prevent constipation, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

PATIENT-STATED GOAL: I don't want anymore falls

GOALS
patient/caregiver recalls
* how to manage complications of immobility including
* skin care
* strength, balance
* dexterity and range-of-motion therapeutic exercises
* promotion of peripheral circulation
* fluid and diet intake to promote healing and prevent constipation

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

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

PT Careplans

PT WK1: 1 (09/20/25-09/20/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, 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 hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, plantarflexion, squats, hip extension. Sitting knee extension, ankle pumps, Bed mobility training , gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * 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, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 06. Independent, Car Transfer - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: Be able to walk by myself without pain

GOALS
Toilet Transfer - 06. Independent

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 - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Car Transfer - 04. Supervision or touching assistance

Walk 10 Feet - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	09/20/2025