Home Health Certification and Plan of Care

Order ID: 1150/15016

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1WE1U64AJ38	12/16/2025	From: 12/16/2025 To: 02/13/2026	20519	217058

6. Patient's Name and Address

Patricia Edel
4313 Fitch Ave Building B,
NOTTINGHAM, MD 21236-
410-668-0347

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 12/22/1950 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S72.351D	Displ commnt fx shaft of r femr 7thD	12/16/25

13. ICD	Other Pertinent Diagnoses	Date
I48.20	Chronic atrial fibrillation unspecified	12/16/25
S51.811D	Laceration w/o foreign body of right forearm subs encntr	12/16/25
S81.812D	Laceration without foreign body left lower leg subs encntr	12/16/25
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	12/16/25
N18.9	Chronic kidney disease u	12/16/25
M10.9	Gout unspecified	12/16/25
F32.A	Depression unspecified	12/16/25
G47.00	Insomnia unspecified	12/16/25
F10.10	Alcohol abuse uncomplicated	12/16/25
F12.10	Cannabis abuse uncomplicated	12/16/25
Z79.01	Long term (current) use of anticoagulants	12/16/25
Z96.653	Presence of artificial knee joint bilateral	12/16/25
Z87.891	Personal history of nicotine dependence	12/16/25
Z91.81	History of falling	12/16/25

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

Folic Acid - Folic Acid 1 mg Take 1 tablet by mouth once a day for supplement
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg oral tablet,Take 1 tablet by mouth every 6 hours as needed for pain
Naloxone Hcl - Naloxone Hydrochloride 1 spray topical as necessary as needed for overdose use 1 spray in nostril for overdose repeat in other nostril in 3 minutes if minimal
Biotin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox Take 1 tablet by mouth once a day for supplement
Sennosides - Senna Take 2 tablet by mouth at bedtime for bowel regimen until
Allopurinol - Allopurinol 100 mg 100mg tablet,take 1 tablet by mouth once a day for gout
Vitamin C - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox Take 500 mg by mouth once a day for supplement
Famotidine - Famotidine 40 mg 40mg; Take 1 tablet by mouth once a day for gerd
Cyanocobalamin - Cyanocobalamin 1 mg 1000 mcg oral tablet,Take 1 tablet by mouth once a day for supplement
Gabapentin - Gabapentin 300 mg 300 mg capsule; 1 tab by mouth three times a day for neuropathy
Metoprolol Tartrate - Metoprolol Tartrate 25 mg 25mg; Take 1 tablet by mouth twice a day for hypertension
Polyethylene Glycol - Polyethylene Glycol 3350: Potassium Chloride: Sodium Bicarbonate: Sodium Chloride Take 17 gram by mouth once a day for bowel regimen dissolve in boz of water hold for loose stools
Trazadone - Trazodone Hydrochloride 100mg oral tablet,Take 1 tablet by mouth at bedtime for depressions
lisinoprill 20mg; take 1 tablet by mouth once a day for hypertension
Enoxaparin Sodium - Enoxaparin Sodium inject 1 syringe intravenous every 12 hours for DVT prophylaxis for 30 days

14. DME and Supplies:

bath bench, rolling walker, walker

15. Safety Measures:

ambulates with device, walker precautions, , infectious material management, sharps precautions, , activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

succinylcholine

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Up As Tolerated, Exercises Prescribed, Walker

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: Yes

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

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Displaced Comminuted Fracture Of The Shaft Of The Right Femur, Specifically For 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 status post open reduction and internal fixation (ORIF) of a right distal femur fracture with placement of a right retrograde femoral nail and incision and drainage (I&D) of the right femur performed on 11/19/25, following a fall at home that resulted in a displaced right femur fracture. The patient also has a history of a right knee revision. Past medical history is significant for chronic atrial fibrillation, hypertension, gout, renal insufficiency, alcohol abuse, and marijuana use. The patient resides alone in a third-floor apartment, with his son providing assistance as needed. At the time of <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was alert and oriented to person, place, and time, reporting right lower extremity pain rated at 4/10 after taking oxycodone prior to the visit. He denied shortness of breath. Lung sounds were diminished throughout. Appetite was reported as fair but improving, with the last bowel movement occurring the day prior to <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>. No edema was noted. Examination of the right knee revealed a closed surgical incision that was clean, dry, and intact, with no signs or symptoms of infection. Hyperpigmentation of the right lower extremity was observed. The patient was ambulating with a walker to promote safety. Skilled nursing reviewed all medications with the patient, including name, dose, frequency, and pertinent side effects. Education was provided on the proper administration of Lovenox, as well as safe sharps disposal, and the patient verbalized understanding. Skilled nursing services are ordered at a frequency of twice weekly for two weeks, then once weekly for two weeks. Physical therapy and occupational therapy evaluations have been ordered. From a rehabilitation standpoint, the patient was instructed in a home exercise program including straight leg raises, lower extremity abduction/adduction, long arc quadriceps, marching, and heel raises, performed at 10 repetitions for 2 sets. The patient was

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 12/16/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Mohammad Rahnama
9512 HARFORD ROAD
PARKVILLE, MD 21234
PHONE: 410-665-4400 FAX: 14106612420 NPI: 1952458739

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 : 12/03/2025

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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instructed on the importance of compliance with the home exercise program to promote strength, mobility, and functional recovery. Prior to hospitalization, the patient resided in a senior citizens apartment and was independent with basic self-care, functional transfers, and functional mobility, completing household instrumental activities of daily living with assistance from his son for grocery shopping. Currently, the patient presents with decreased standing balance, reduced standing tolerance, diminished bilateral upper extremity strength, and decreased overall activity tolerance, resulting in limitations in self-care, functional transfers, and functional ambulation. Skilled physical therapy and occupational therapy services are recommended to address these deficits, improve functional independence, and promote safe return toward the patient's prior level of function.
 Date of Order 12/16/2025 Orders Physician Face-to-Face Date: 12/03/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Displaced Comminuted Fracture Of The Shaft Of The Right Femur, Specifically For 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: soc PT Eval Notes: OT Eval Notes:
 Physician Rahnama, Mohammad

SN Careplans

SN WK1: 1 (12/16/25-12/20/25) ,WK2: 2 (12/21/25-12/27/25) ,WK3: 1 (12/28/25-01/03/26) ,WK4: 1 (01/04/26-01/10/26)

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: 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will 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, 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, 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; 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, meal preparation, M2102c - Med Admin, M1033 - Exhaustion, M1400 - Dyspnea, lung sounds not clear, limited range of motion, limited endurance, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, bruising/discoloration, #1 - Other - Anterior Right Knee - CLOSED INCISION NO S/S OF INFECTION NOTED

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, physician-ordered wound care: RIGHT LEG CLOSED INCISION OPEN TO AIR.

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, * strict compliance with physician orders for anticoagulant administration avoiding activities that create unnecessary risk for injury monitoring for prolonged bleeding from cuts, blood in urine or stool, or unusual bruising for warfarin, limiting foods high in Vitamin K, such as leafy green vegetables, * 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 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * how to manage gout flare-ups including non-medical pain relief dietary modifications, 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, * 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

SN Goals

PATIENT-STATED GOAL: I want to be safe and walk better

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 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 gout flare-ups including non-medical pain relief
* dietary modifications
* 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
* strict compliance with physician orders for anticoagulant administration
* avoiding activities that create unnecessary risk for injury
* monitoring for prolonged bleeding from cuts, blood in urine or stool, or unusual bruising
* for warfarin, limiting foods high in Vitamin K, such as leafy green vegetables

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

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

patient/caregiver recalls

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/16/2025

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* 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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

PT Careplans

PT WK1: 1 (12/16/25-12/20/25) ,WK3: 1 (12/28/25-01/03/26) ,WK4: 1 (01/04/26-01/10/26) ,WK5: 1 (01/11/26-01/17/26) ,WK6: 1 (01/18/26-01/24/26) ,WK7: 1 (01/25/26-01/31/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 Dyspnea, 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: Medication Review: The medication was reviewed with the patient , Home exercises : Slr, heel slides, slr, le abd/add, long arc . marching and heel raises --10x2 reps, cough/deep breathing exercises, incentive spirometer, 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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT Goals

PATIENT-STATED GOAL: To walk with out device

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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 - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK1: 1 (12/16/25-12/20/25) ,WK4: 1 (01/04/26-01/10/26) ,WK5: 1 (01/11/26-01/17/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

PROCEDURES: Medication Review : Medication reviewed with patient. Medication taken prior to treatment session., cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation, transfers training, assist with bathing, assist with upper body dressing, therapeutic 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 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: Get off the pot better

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

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Lower Body Dressing - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
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Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

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