Home Health Certification and Plan of Care

Order ID: 1150/15862

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
9QG6X88QN64	01/28/2026	From: 01/28/2026 To: 03/28/2026	21723	217058

6. Patient's Name and Address

Evelyn Royahn
7905 HIlltop Ave,
NOTTINGHAM, MD 21236-
443-648-1098

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 06/05/1926 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S72.401D	Unsp fx lower end of r femur subs for clos fx w routn heal	01/28/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	01/28/26
E78.00	Pure hypercholesterolemia unspecified	01/28/26
I27.20	Pulmonary hypertension unspecified	01/28/26
F43.21	Adjustment disorder with depressed mood	01/28/26
I44.1	Atrioventricular block second degree	01/28/26
I69.321	Dysphasia following cerebral infarction	01/28/26
K59.09	Other constipation	01/28/26
I65.23	Occlusion and stenosis of bilateral carotid arteries	01/28/26
M19.90	Unspecified osteoarthritis unspecified site	01/28/26
H40.9	Unspecified glaucoma	01/28/26
E66.813	Other obesity	01/28/26
Z68.42	Body mass index [BMI] 45.0-49.9 adult	01/28/26
Z79.82	Long term (current) use of aspirin	01/28/26
Z79.891	Long term (current) use of opiate analgesic	01/28/26
Z91.81	History of falling	01/28/26

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

Polyvinyl Alcohol-Povidone PF Ophthalmic Solution 1.4-0.6 % (Polyvinyl Alcohol-Povidone Ophthal) 1 drop in both eyes every 6 hours as needed for glaucoma.
Senna-Docusate Sodium Oral Tablet 8.6-50 MG (Senna-Docusate Sodium) 2 tablets by mouth at bedtime for Bowel Regimen First weekly MDAP for Loose Stool.
Gabapentin - Gabapentin 100 mg 1 Tablet by mouth every 8 hours Give 1 tablet by mouth every 8 hours for Neuropathy for 60 Days Monitor sedation
Melatonin - Melatonin 3 mg / 1 Tablet by mouth at bedtime for Sleep aide.
Latanoprost - Latanoprost 0.005 perc 1drop both eyes at bedtime for glaucoma.
Furosemide - Furosemide 20 mg / 1 Tablet by mouth once a day for EDEMA.
Acetaminophen - Acetaminophen 325 mg / 1 Tablet by mouth every 8 hours Give 2 tablet by mouth every 8 hours for Pain do not exceed more than 3 grams per day from all sources
Aspirin Ec - Aspirin 81 mg / 1 Tablet by mouth twice a day for CAD
Atorvastatin Calcium - Atorvastatin Calcium 40 mg / 1 Tablet by mouth at bedtime Give 40 mg by mouth at bedtime for HLD
Bisacodyl Rectal Suppository 10 mg rectal - Insert 1 suppository rectally every 24 hours as needed for CONSTIPATION
Ergocalciferol - Ergocalciferol 1.25 MG (50000 UT) capsule by mouth once a day every Mon for SUPPLEMENT
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) mg / 1 Tablet by mouth once a day for SUPPLEMENT
Glycolax - Polyethylene Glycol 3350 17gm/packet - by mouth once a day for constipation Mix well in a full glass (120-240 ml or 4-8 oz) of water, juice, soda, coffee or tea prior to administration
PreserVision AREDS 2 Oral Capsule (Multiple Vitamins w/ Minerals) 1 Capsule by mouth twice a day for supplement
Diclofenac - Diclofenac Epolamine 1% cream 4.5 (4grams) inches topical four times a day Apply 4.5 inches of cream to knees 4 times daily for pain.

14. DME and Supplies:

wheelchair, rolling walker, bath bench, walker, grab bars, hospital bed, 4 wheeled walker

15. Safety Measures:

walker precautions, smoke detectors , , , , ambulates with device, transfer with assist, supervision at all times, bedrails up while in bed, ambulates with assistance, wheelchair precautions, hand rails, bathroom safety, , activity supervision

16. Nutrition:

cardiac diet

17. Allergies:

no known allergies

18.A. Functional Limitations

Legally Blind, Endurance, Bowel/Bladder Incontinence, Ambulation

18.B. Activities Permitted

Exercises Prescribed, Walker, Up As Tolerated

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, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

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

family/caregiver will be responsible for managing treatment

Homebound status:

Due to diagnosis of Unspecified Fracture Of Lower End Of Right Femur, 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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 01/28/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Bradford Ebright
9524 Belair Rd
Baltimore, MD 21236
PHONE: 4105299311 FAX: 14105290085 NPI: 1053316158

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 : 01/15/2026

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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Evelyn Royahn 7905 HIlltop Ave, NOTTINGHAM, MD 21236- 443-648-1098	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Clinical Condition Requiring Homecare:

The patient is a 99-year-old female who resides alone in a single-family home. Her bedroom is located on the main living level, and she utilizes a hospital bed. The patient has a complex social history, having had four children and two spouses; both spouses are deceased, and she reports no current relationship with her children. Over time, she developed a supportive relationship with her mail carrier, who, along with her partner, assumed a caregiving role as the patient's health declined. The patient currently has paid caregivers providing 24-hour assistance in the home. She is designated as DNR/DNI. In October 2025, the patient sustained a mechanical fall in her home resulting in a femur fracture. She underwent open reduction and internal fixation (ORIF) and subsequently completed a rehabilitation stay. She has now been discharged home and is appropriate for skilled therapy services. While in rehabilitation, the patient reported ambulating up to 18 steps with assistance prior to discharge; however, since returning home, she has been unable to ambulate. Durable medical equipment available in the home includes a walker, wheelchair, shower chair, and hospital bed. The patient's past medical history is significant for hyperlipidemia, hypertension, right middle cerebral artery cerebrovascular accident, osteoarthritis, carotid stenosis, significant visual impairment, and glaucoma. At the time of evaluation, the patient denied pain. She was met resting in bed and is more than three months status post ORIF. All prescribed medications were present in the home, and medication education was provided to both the patient and caregiver. A written <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-14 CE-FMS-medication%20list">medication list</mh> and calendar were completed and placed on the refrigerator for reference to support medication compliance and care coordination. Functionally, prior to her fall, the patient was independent with basic self-care tasks, requiring supervision for bathing only, and received assistance with instrumental activities of daily living such as laundry, grocery shopping, and household cleaning. Currently, the patient demonstrates decreased standing balance, standing tolerance, bilateral upper extremity strength, and overall activity tolerance, resulting in limitations with self-care tasks, functional transfers, and functional ambulation. During the visit, the patient was instructed in a home exercise program, including straight leg raises and leg press exercises. She was assisted to a seated position with feet supported on the floor and required two-person assistance to transition to standing using a walker. The patient was assisted to stand three times during the session. Caregiver education was provided regarding safe assistance and reinforcement of the prescribed home exercise program. Skilled physical and occupational therapy services are recommended to address the patient's current functional deficits, improve strength, balance, and tolerance to activity, and promote safe mobility and self-care with the goal of maximizing independence and returning the patient as close as possible to her prior level of function while ensuring safety in the home environment.
 Date of Order 01/28/2026 Orders Physician Face-to-Face Date: 01/15/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Unspecified Fracture Of Lower End Of Right Femur, 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 Ebright, Bradford

SN Careplans

SN WK1: 1 (01/28/26-01/31/26) ,WK2: 1 (02/01/26-02/07/26) ,WK3: 1 (02/08/26-02/14/26) ,WK4: 1 (02/15/26-02/21/26) ,WK5: 1 (02/22/26-02/28/26) ,WK6: 1 (03/01/26-03/07/26) ,WK7: 1 (03/08/26-03/14/26) ,WK8: 1 (03/15/26-03/21/26) ,WK9: 1 (03/22/26-03/27/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 5. Decline in mental, emotional, or behavioral status in the past 3 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

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

SN Goals

PATIENT-STATED GOAL: Patient states she wants to be able to walk again to her kitchen so she can cook again

GOALS
patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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 relaxatio

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 medicatio

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
* bowel incontinence management including dietary changes
* bowel training
* skin care
* 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

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/28/2026

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Advance Directive:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: , M1700 - Cognition, M1720 - Anxiety, M1745 - Behavioral Issues, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, M2020 - Oral Med Management, dependent edema, M1400 - Dyspnea, M1033 - Exhaustion, M1620 - Bowel Incontinence, limited endurance, limited strength, poor muscle tone, muscle weakness, limited range of motion, weak hand grips, B0200 - Hearing Deficit, B1000 - Vision Deficit, Pain Interference with ADLs, Pain Effect on Sleep, daytime fatigue, difficulty sleeping, obesity

PROCEDURES: incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange resources for vision-impaired, coordinate/arrange home modifications for hearing impaired, i.e. alarms

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 medicatio, * 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 relaxatio, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related m, * how to keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/C O2 alarms, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpos

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 m

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

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (01/28/26-01/31/26) ,WK2: 2 (02/01/26-02/07/26) ,WK3: 2 (02/08/26-02/14/26) ,WK4: 2 (02/15/26-02/21/26) ,WK5: 2 (02/22/26-02/28/26) ,WK6: 1 (03/01/26-03/07/26) ,WK7: 1 (03/08/26-03/14/26) ,WK8: 1 (03/15/26-03/21/26)

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, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet

PROCEDURES: Medication Review: The medication was reviewed with the patient , cough/deep breathing exercises, incentive spirometer, wheelchair training, 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 medicatio, * 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 relaxatio, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: To walk again

GOALS
Chair to Bed to Chair - 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 medicatio

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 relaxatio

Sit to Stand - 06. Independent

Toilet Transfer - 05. Setup or clean-up assistance

Car Transfer - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

OT Careplans

OT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

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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's caregiver with all medications in the home , equipment training, work simplification/energy conservation, transfers training, assist with bathing, assist with toilet transferring, assist with lower body dressing, assist with upper body dressing

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 medicatio, * 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 relaxatio, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent

PATIENT-STATED GOAL: Walk 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 medicatio

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 relaxatio

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

01/28/2026