Home Health Certification and Plan of Care

Order ID: 1150/16392

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01234238	02/17/2026	From: 02/17/2026 To: 04/17/2026	22671	217058

6. Patient's Name and Address

Debra Laukeman-Michalski
7907 Roseland Ave,
ROSEDALE, MD 21237-
443-804-9689

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 03/23/1951 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S72.042D	Disp fx of base of nk of l femr 7thD	02/17/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	02/17/26
I10.	Essential (primary) hypertension	02/17/26
E22.2	Syndrome of inappropriate secretion of antidiuretic hormone	02/17/26
D72.829	Elevated white blood cell count unspecified	02/17/26
E78.49	Other hyperlipidemia	02/17/26
Z79.01	Long term (current) use of anticoagulants	02/17/26
Z91.81	History of falling	02/17/26

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

Lisinopril - Lisinopril 40 mg / 1 Tablet by mouth once a day for HTN
Fluticasone-Salmeterol 250-50 MCG/ACT Aerosol Powder, breath activated 1 inhalation orally two times a day for COPD
Acetaminophen - Acetaminophen 500 mg / 1 Tablet by mouth every 8 hours Take 2
tablets for Pain
Albuterol Sulfate - Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT / 2 puff by mouth every 4 hours as needed for Asthma
Atorvastatin Calcium - Atorvastatin Calcium 10 mg / 1 Tablet by mouth once a day for
HLD
Amlodipine Besylate - Amlodipine Besylate eq 5 mg base eq 5 mg base / 1 Tablet by mouth once a day Take 2 tablets for
HTN
Labetalol Hydrochloride - Labetalol Hydrochloride 200 mg 200 mg / 1 Tablet by mouth twice a day for HTN

14. DME and Supplies:

rolling walker, hand held shower, bath bench, walker, 4 wheeled walker

15. Safety Measures:

walker precautions, smoke detectors , medication safety, fall precautions, bleeding precautions, ambulates with device, hip precautions, ambulates with assistance, , transfer with assist, standard precautions, hand rails, bathroom safety, anticoagulant precautions, activity supervision

16. Nutrition:

2gm sodium

17. Allergies:

sulfa antibiotics sulfamethoxazole/trimetoprim

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Walker, Exercises Prescribed, 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: good

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

another facility/provider will be responsible for managing treatment

Homebound status: Due to diagnosis of Displaced fracture of base of neck of left 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.

Clinical Condition Requiring Homecare: Ms. Laukeman is a 74-year-old female with a past medical history significant for SIADH, hyponatremia, reactive airway disease, and hypertension who was hospitalized following a mechanical fall resulting in a left subcapital femoral fracture confirmed by hip and pelvis X-ray. She is status post left hip hemiarthroplasty and has returned home from rehabilitation at Autumn Lake Summit Park. Her surgical incision is clean, dry, intact, and fully healed. She resides in a single-family home with assistance from her daughter; all medications are available in the home, and she is a full code with a MOLST on file. The patient ambulates with a walker and has a cane available. She currently presents with postoperative edema, pain, generalized weakness, and decreased left lower extremity strength (3-/5). Therapeutic exercises were initiated, including ankle pumps, heel slides, assisted left hip abduction/adduction in long sitting, and long arc quadriceps exercises in sitting (10 repetitions 2 sets), along with training in bed mobility and proper use of a rolling walker emphasizing a heel-to-toe gait pattern. Prior to hospitalization, she was independent with basic self-care, functional mobility, driving, meal preparation, and laundry in her two-story home; however, she now demonstrates decreased standing balance, tolerance, bilateral upper extremity strength, and overall activity tolerance, impacting her ability to perform ADLs and IADLs. Skilled PT and OT services are recommended to address these deficits and facilitate a safe return to her prior level of function.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 02/17/2026
 Order<o:p></o:p> Physician Face-to-Face Date: 02/10/2026
 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PT eval and treat, OT eval and treat DX : Displaced fracture of base of neck of left 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<o:p></o:p>
 1 - SOC - SN Notes:<o:p></o:p> PT Eval Notes:
 OT Eval Notes:<o:p></o:p> Physician:<span style="font-size: 10.5pt; background-image: initial; background-position: initial; background-size: initial; background-repeat: initial; background-attachment: initial; background-origin: initial; background-clip: initial;"> Sanico, Barbara

SN Careplans

SN WK1: 1 (02/17/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26)

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), 7. Currently taking 5 or more medications

SN Goals

PATIENT-STATED GOAL: Patient states she wants to be able to shop by herself again for her own groceries.

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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/17/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Barbara Sanico
4920 Campbell Blvd
Baltimore, MD 21236
PHONE: 410-933-7600 FAX: NPI: 1164454716

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 : 02/10/2026

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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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: M2020 - Oral Med Management, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

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

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 2 (02/17/26-02/21/26) ,WK2: 3 (02/22/26-02/28/26) ,WK3: 3 (03/01/26-03/07/26) ,WK4: 2 (03/08/26-03/14/26) ,WK5: 2 (03/15/26-03/21/26) ,WK6: 2 (03/22/26-03/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea, GG0170I1 - Walk 10 Feet, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, 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: cough/deep breathing exercises, incentive spirometer, 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 relaxation skills and diversional activities, related medication(s) purpose, schedule, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: To walk straight

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Car 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 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 relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

Walk 10 Feet - 04. Supervision or touching assistance

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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/17/2026

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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

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

Sit to Stand - 06. Independent

OT Careplans

OT WK1: 1 (02/17/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK5: 1 (03/15/26-03/21/26) ,WK6: 1 (03/22/26-03/28/26)

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 with all medications in the home. , cough/deep breathing exercises, incentive spirometer, therapeutic exercises, equipment training, work simplification/energy conservation, assist with bathing, assist with transferring, assist with lower 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 - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Walk better

GOALS
Shower/Bathe Self - 05. Setup or clean-up 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 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 - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:

Date

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

Date
02/17/2026