Home Health Certification and Plan of Care

Order ID: 1150/16489

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
81187501	02/21/2026	From: 02/21/2026 To: 04/21/2026	22731	217058

6. Patient's Name and Address
Chanelle Holloway
3509 WASHINGTON AVE,
WINDSOR MILL, MD 21244-
410-907-1727

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 09/21/1980 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S82.52XD	Disp fx of med malleolus of l tibia 7thD	02/21/26

13. ICD	Other Pertinent Diagnoses	Date
S91.011D	Laceration without foreign body right ankle subs encntr	02/21/26
S91.311D	Laceration without foreign body right foot subs encntr	02/21/26
I10.	Essential (primary) hypertension	02/21/26
R73.03	Prediabetes	02/21/26
E78.2	Mixed hyperlipidemia	02/21/26
Z94.5	Skin transplant status	02/21/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	02/21/26
Z79.82	Long term (current) use of aspirin	02/21/26

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

Lipitor - Atorvastatin Calcium 0 20 mg / 1 Tablet by mouth once a day
Protonix Delayed Release 0 0 40 mg / 1 Tablet by mouth once a day Hold until cleared by dr
Iron - Ferrous Sulfate: Folic Acid 65 mg tablet by mouth once a day Iron supplement
Methocarbamol - Methocarbamol 500 mg 1 tablet by mouth three times a day
Tylenol - Acetaminophen 500mg tablet, 1-2 tablets by mouth every 8 hours As needed for pain
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 10 mg, cut in half by mouth every 6 hours As needed for pain, 6-8 hours
Melatonin - Melatonin 1 tablet 10 mg by mouth at bedtime For insomnia
Asprin - Aspirin 0 81 mg chewable tablet, Take 1 tablet (81 mg total) by mouth twice a day Heart health

14. DME and Supplies:
wheelchair, hand held shower, bath bench, walker, reacher, wound care supplies

15. Safety Measures:
infectious material management, , ambulates with assistance, wheelchair precautions, , hand rails, bathroom safety

16. Nutrition:
regular

17. Allergies:
orange pineapple topiramate

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
Walker, 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
patient will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Displaced Fracture Of Medial Malleolus Of Left Tibia, 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 45-year-old female with a past medical history significant for hypertension, hyperlipidemia, diabetes/prediabetes, who was hospitalized following a traumatic accident on 01/15/2026 in which she was run over by a trash truck. Injuries sustained included a large degloving injury to the right lower leg and dorsal foot, as well as a left medial malleolus fracture. She was transferred to an acute rehabilitation facility on 02/09/2026 and discharged home on 02/20/2026. Prior to hospitalization, the patient was independent with all mobility and activities of daily living without the use of an assistive device. She now presents with generalized weakness, easy fatigability, impaired mobility, and significant functional decline. The patient is wheelchair-dependent for primary mobility and is able to ambulate short distances (approximately 15 feet at a time) using a rolling walker with contact guard assistance while hopping on the right lower extremity. She is non-weight bearing on the left lower extremity and weight bearing as tolerated on the right lower extremity with a CAM boot. Manual muscle testing reveals bilateral lower extremity strength of approximately 3/5, limited by weight-bearing restrictions. She requires supervision to contact guard/minimal assistance for sit-to-stand and commode transfers while maintaining precautions, contact guard assistance for upper body dressing, minimal assistance for lower body dressing, and is currently performing sink-side bathing. She requires assistance with stair negotiation and is unable to leave the home safely without assistance, placing her at high risk for falls. The patient has multiple traumatic and surgically managed wounds to the right lower extremity extending from the lower leg to the foot. Wound #1, located on the right lower leg with a donor site from the right upper thigh, measures 10 cm x 4 cm x 0.1 cm and demonstrates 100% granulation tissue with moderate serosanguineous drainage. Wound #2, located on the outer right foot, measures 15 cm x 7 cm x 9.2 cm and demonstrates 100% granulation tissue with moderate serosanguineous drainage. Wound #3, located on the right inner dorsal foot, measures 2 cm x 2.5 cm x 0.2 cm with 100% granulation tissue and moderate serosanguineous drainage. Wound #4, located on the right inner lower foot, measures 4 cm x 8 cm x 0.2 cm with 100% granulation tissue and moderate serosanguineous drainage. Wound #5, located on the right anterior foot, measures 1 cm x 8 cm x 0.3 cm, also with 100% granulation tissue and moderate serosanguineous drainage. No necrotic tissue is noted in the documented wounds. The patient also has a cast in place to the left lower extremity. She reports pain at rest and with activity. Given the patient's significant mobility limitations, weight-bearing restrictions, decreased strength, impaired balance, wound burden, and high fall risk, she requires skilled services. Physical therapy evaluation was completed, and the patient demonstrates decreased strength, impaired functional mobility, reduced endurance, and decreased safety with transfers and ambulation. She requires supervision to contact guard assistance for transfers and short-distance ambulation with a rolling walker. Skilled physical therapy is medically necessary to address strength deficits, improve balance, enhance safety awareness, reinforce adherence to weight-bearing precautions, and restore functional mobility toward her prior level of function. The patient resides with family in a two-level home, and caregiver support is available; however, due to current impairments, she remains homebound and dependent on assistance for safe mobility and ADLs. The plan of care includes continued skilled nursing for wound <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> and management, monitoring for signs and symptoms of infection, pain management, and reinforcement of safety education, as well as skilled physical therapy to improve lower extremity strength, balance, endurance, and transfer and gait safety while adhering to weight-bearing precautions. The goal is to promote wound healing, prevent complications, reduce fall risk, and progressively improve independence in functional mobility and activities of daily living.
 Date of Order 02/21/2026 Orders Physician Face-to-Face Date: 02/13/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Displaced Fracture Of Medial Malleolus Of Left Tibia, 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 Nadeem, Faryal

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 02/21/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Faryal Nadeem
7141 Security Blvd
Windsor Mill, MD 21244
PHONE: 800-777-7904 FAX: NPI: 1699138537

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 : 02/13/2026

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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SN WK1: 1 (02/21/26-02/21/26) ,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)

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: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 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; 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: M1720 - Anxiety, M2020 - Oral Med Management, Home Safety, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, M1400 - Dyspnea, swelling in the arms/legs, limited endurance, swelling of affected area, muscle weakness, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, swell/redness surround. skin, #1 - Observable Surgical Wound - Other - Right upper thigh, donor surgical site - no drainage, open to air., #2 - Laceration - Other - Right outer foot trauma wound - , #3 - Laceration - Other - Right inner foot top trauma wound - , #4 - Laceration - Other - Right Inner Foot lower trauma wound - , #5 - Laceration - Other - Right anterior foot trauma wound -

PROCEDURES: physician-ordered wound care: #5 - Laceration - Other - Right anterior foot trauma wound -, physician-ordered wound care: #4 - Laceration - Other - Right Inner Foot lower trauma wound -, physician-ordered wound care: #3 - Laceration - Other - Right inner foot top trauma wound -, physician-ordered wound care: #2 - Laceration - Other - Right outer foot trauma wound -, physician-ordered wound care: #1 - Observable Surgical Wound - Other - Right upper thigh, donor surgical site - no drainage, open to air.: To right thigh donor surgical site, open to air., cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: Wound Care to the RLE/ Foot: Remove dressing cleanse wounds/foot with wound cleanser rinse with normal saline or small amounts of VASHE. Apply Aquaphor to healed portions of the skin graft. Paint/ blot all open red areas with betadine swab. Allow to air dry 1-2 mins. Then cover all with Xeroform, dry gauze or ABD pad and kerlix. Ace wrap toe to knee. Change daily, glucose testing via monitor

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, * strategies to increase caloric intake, 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, patient's living environment is clean/uncluttered

PATIENT-STATED GOAL: to be independent again

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

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 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/caregiver recalls
* strategies to increase caloric intake
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's living environment is clean/uncluttered

PT Careplans

PT 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) ,WK7: 1 (03/29/26-04/04/26) ,WK8: 1 (04/05/26-04/11/26) ,WK9: 1 (04/12/26-04/18/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, 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: Medication Review: - medications reviewed with patient/caregiver, Review of weight bearing restrictions : NWB on LLE, weight bearing only with CAM boot on RLE, gait training/stair training

TEACH PATIENT/CAREGIVER: Medication Review

PT Goals

PATIENT-STATED GOAL: To be able to walk again

GOALS
Medication Review

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Signature of Physician:

Date

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

Date
02/21/2026

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Car Transfer - 05. Setup or clean-up assistance

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

OT Careplans

OT 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)

PROBLEMS IDENTIFIED ON ASSESSMENT: , M1400, 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: Therapeutic exercises , Patient/caregiver recalls related purpose and schedule of medications: Medication review , cough/deep breathing exercises, 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, 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, Upper Body Dressing - 06. Independent, Patient will demonstrate improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

OT Goals

PATIENT-STATED GOAL: Patient wants to get stronger and 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

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

Upper Body Dressing - 06. Independent

Patient will demonstrate improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

02/21/2026