Home Health Certification and Plan of Care

Order ID: 1150/16541

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
96315039	02/20/2026	From: 02/20/2026 To: 04/20/2026	22281	217058

6. Patient's Name and Address
Morese Woodrum
58 W Biddle St Apt 102,
BALTIMORE, MD 21201
443-691-6499

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 08/09/1942 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
M80.051D	Age-rel osteopor w crnt path fx r femr 7thD	02/20/26

13. ICD	Other Pertinent Diagnoses	Date
J44.9	Chronic obstructive pulmonary disease unspecified	02/20/26
I10.	Essential (primary) hypertension	02/20/26
D64.9	Anemia unspecified	02/20/26
D47.2	Monoclonal gammopathy	02/20/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	02/20/26
E44.0	Moderate protein-calorie malnutrition	02/20/26
K21.9	Gastro-esophageal reflux disease without esophagitis	02/20/26
F11.20	Opioid dependence uncomplicated	02/20/26
Z79.51	Long term (current) use of inhaled steroids	02/20/26
Z87.891	Personal history of nicotine dependence	02/20/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	02/20/26
Z87.01	Personal history of pneumonia (recurrent)	02/20/26

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

Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT / 2 puff inhalant as necessary inhale orally every 4 hours as needed for SOB/Wheezing
Acetaminophen - Acetaminophen 0 0 325 mg / 1 Tablet by mouth as necessary Give 2 tablet every 6 hours for mild pain (1-4) not to exceed 3 grams of acetaminophen from all sources in a 24 hr period
Tiotropium Bromide Inhalation Capsule 0 18 mcg by mouth once a day Inhale orally for COPD
Tums - Simethicone 2 chewable tablets by mouth as necessary for heart burn
Magnesium Oxide - Simethicone 1 tablet by mouth once a day
Centrum Multivitamin - Ascorbic Acid: Biotin: Cyanocobalamin: Ergocalciferol: Folic Acid: Niacinamide: Pantothenic Acid: Phytonadione: Pyridoxine: Ribo 1 tablet by mouth once a day

14. DME and Supplies:
walker, rolling walker,

15. Safety Measures:
walker precautions, ambulates with device, , , bathroom safety, hip precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Up As Tolerated, Walker

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, 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 Age-Related Osteoporosis With Current Pathological Fracture, Right Femur, 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: <div><span style="font-size: 14px;">The patient is an 83-year-old male with a past medical history significant for hypertension, depression, opioid use disorder, gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), and additional comorbidities. He was admitted to home health services following a recent fall that resulted in a femur fracture requiring surgical repair on 12/27. After a short stay in an acute care facility, he was transferred to a skilled nursing facility for rehabilitation and has now returned home for continued care and monitoring. On assessment, the patient was alert and oriented to person, place, time, and situation. He denied current pain and did not exhibit signs of acute distress. Respiratory assessment revealed diminished breath sounds at the lung bases; however, no acute respiratory compromise was noted. Bowel sounds were active in all quadrants, and the patient reported his last bowel movement occurred yesterday. Vital signs were obtained and were within acceptable parameters at the time of evaluation. The patient ambulates with a rollator for support and stability; when not using the rollator, he relies on surrounding furniture for assistance, indicating ongoing fall risk. He resides alone in a one-room living space with a private bathroom and reports independence in simple meal preparation using a microwave. His daughter provides intermittent support, checking on him periodically and assisting with ensuring attendance at medical appointments. A comprehensive home health assessment was completed, and the patient was formally admitted to services for continued monitoring, fall risk management, postoperative recovery support, and management of chronic medical conditions. Education was provided regarding safe ambulation with assistive devices, fall prevention strategies, and the importance of medication adherence and follow-up care. The plan of care includes skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> for ongoing assessment of respiratory status, surgical recovery, pain management, medication management, and reinforcement of safety measures to promote optimal recovery and prevent rehospitalization.</div><div>
</div><div>Date of Order</div><div>02/20/2026</div><div>Orders</div><div>Physician Face-to-Face Date: 01/27/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Age-Related Osteoporosis With Current Pathological Fracture, Right Femur, Subsequent Encounter For Fracture With Routine Healing</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div>
</div><div>1 - SOC - SN Notes: soc</div><div>Physician</div><div>Mathew, Alyssa</div>

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 02/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Alyssa Mathew
4920 Campbell Blvd
Baltimore, MD 21236
PHONE: FAX: NPI: 1144640269

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 : 01/27/2026

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 Careplans

SN WK1: 1 (02/20/26-02/21/26) ,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)

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: 4. Assistance needed, but no non-agency caregiver(s) available

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 months, 7. Currently taking 5 or more medications

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, SP02: 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, D0700 - Social Isolation, M2020 - Oral Med Management, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, coughing, lung sounds not clear, heartburn/indigestion, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange long-term socialization activities, venipuncture: Patient requires the following labs: Vitamin D (red top), Thyroid panel- Free T4, TSH (yellow top), Hemoglobin A1C (purple top), Comprehensive Metabolic Panel (yellow top), Lipid panel- DLDL, HDL, CHOL, TRIG (YELLOW TOP), WBC Auto-diff (yellow), CBC no diff (purple top)

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: I want to be more 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
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/20/2026