

Home Health Certification and Plan of Care				Order ID: 1150/18537							
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period		4. Medical Record No.		5. Provider No.			
47356514		05/08/2026		From: 05/08/2026 To: 07/06/2026		25624		217058			
6. Patient's Name and Address Amanda Steber 3027 Westfield Avenue, Baltimore, MD 21214- 410-736-1066					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 03/05/1986 9. Sex Female					10. Medications: Dose/Frequency/Route (N)ew (C)hanged ACETAMINOPHEN 500 mg/tablet / Take 2 tablets by mouth every 6 (six) hours for 10 days. Commonly known as: TYLENOL Cholecalciferol 25 MCG (1000 UT) / 1 Tablet by mouth once a day Commonly known as: VITAMIN D3 Calcium Carbonate 200 mg calcium (500 mg) chewable / Take 2 tablets (1000 mg total) by mouth twice a day with meals. Commonly known as: TUMS GABAPENTIN 300 mg / 1 Capsule by mouth every 8 (eight) hours Commonly known as: NEURONTIN HYDROMORPHONE HYDROCHLORIDE 4 mg / 1 Tablet by mouth every 4 (four) hours as needed For diagnoses: Trauma, Multiple closed fractures of pelvis with unstable disruption of pelvic ring, initial encounter, Closed displaced comminuted fracture of shaft of right femur, initial encounter. Commonly know as: DILAUDID METHOCARBAMOL 500 mg / 1 Tablet by mouth every 8 (eight) hours for 10 days. Commonly known as: ROBAXIN Motrin - Ibuprofen 200mg (3) by mouth as necessary						
11. ICD S72.351D			Principal Diagnosis Displ commnt fx shaft of r femr 7thD			Date 05/08/26					
13. ICD S22.41XD S32.811D S01.01XD J45.909 G40.909 K76.0 N28.0 D72.829 F10.10 I95.9 Z72.0 Z91.81			Other Pertinent Diagnoses Multiple fx of ribs right side subs for fx w routn heal Mult fx of pelv w unstbl disrupt of pelv ring 7thD Laceration without foreign body of scalp subs encntr Unspecified asthma uncomplicated Epilepsy unsp not intractable without status epilepticus Fatty (change of) liver not elsewhere classified Ischemia and infarction of kidney Elevated white blood cell count unspecified Alcohol abuse uncomplicated Hypotension unspecified Tobacco use History of falling			Date 05/08/26 05/08/26 05/08/26 05/08/26 05/08/26 05/08/26 05/08/26 05/08/26 05/08/26 05/08/26 05/08/26					
14. DME and Supplies: cane, walker					15. Safety Measures: bathroom safety, supervision at all times, standard precautions, wheelchair precautions, fall precautions, activity supervision, ambulates with assistance, ambulates with device						
16. Nutrition: regular					17. Allergies: no known allergies						
18.A. Functional Limitations Ambulation, Endurance					18.B. Activities Permitted 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: good											
22. A Rehabilitation Potential: SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.					22.B.Discharge Plans patient will be responsible for managing treatment						
Homebound status: Due to diagnosis of Displaced comminuted fracture of shaft 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											
Clinical Condition Requiring Homecare: <p class="MsoNoSpacing">SOC completed and consents signed by patient. Patient is a 40-year-old male s/p pedestrian versus truck accident on 4/24/26 resulting in right femur fracture, multiple rib fractures, sacral fracture, and multiple pelvic fractures. Patient underwent ORIF of the right femur on 4/25/26 and pelvic surgery on 4/27/26. PMH significant for alcohol abuse with history of withdrawal seizures. Patient is alert and oriented x3-4 and reports pain to the pelvis, ribs, and right leg rated at 8/10. Patient remains non-weight-bearing for 10 weeks and is currently non-ambulatory, requiring one-person assistance with ADLs, transfers, and mobility, making it a taxing effort to leave the home. Patient lives with mother in a home with 8 steps to enter; however, bed and commode are set up on the first floor. Family, including mother and twin sister, assist with toileting and transfers. Bed mobility is independent, and patient performs bed-to-commode transfers with supervision. Patient requires a transfer board for wheelchair transfers and needs wheelchair elevating leg rests and cushion due to NWB status. Wound vac remains in place to the right thigh following femur fracture repair and is set to continuous suction, with possible removal at surgical follow-up appointment on 5/20/26. No wound complications, abnormal bleeding, urinary discomfort, abnormal lung sounds, or falls reported. Patient reports bowel movement today, though small due to abdominal pressure. Patient tolerated therapeutic exercises including supine hip flexion, straight leg raises, hip abduction, sidelying hip abduction, prone knee flexion, hip extension, and upper body weight-bearing activities. Patient is homebound as evidenced by significant effort required to leave home and Tinetti score of 1/28. Skilled nursing frequency ordered 1w5, and home PT services are medically necessary to improve strength, transfers, functional mobility, pain management, and overall independence until weight-bearing status advances and ambulation can resume.<o:p></o:p></p> <p class="MsoNoSpacing"><o:p> </o:p></p> <p class="MsoNoSpacing">Date of Order<o:p></o:p></p> <p class="MsoNoSpacing">05/08/2026 Order<o:p></o:p></p> <p class="MsoNoSpacing">Physician Face-to-Face Date: 05/05/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat dx: Displaced comminuted fracture of shaft 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<o:p></o:p></p> <p class="MsoNoSpacing"> 1 - SOC - SN Notes:<o:p></o:p></p> <p class="MsoNoSpacing">PT Eval Notes:<o:p></o:p></p> <p class="MsoNoSpacing">Physician: Kinn, Angela</p>											
SN Careplans					SN Goals						
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 05/08/2026										25. Date HHA Received Signed POT	
24. Physician's Name and Address Angela Kinn 5505 Hopkins Bayview Cir Baltimore, MD 21224 PHONE: 4105500925 FAX: NPI: 1770530008					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 : 05/05/2026						
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. PAGE 1 of 3						

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SN WK1: 1 (05/08/26-05/09/26) ,WK2: 1 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26) ,WK4: 1 (05/24/26-05/30/26) ,WK5: 1 (05/31/26-06/06/26)	PATIENT-STATED GOAL: Pain control and regain independence with mobility
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	GOALS 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
CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance	caregiver administers and/or packages medications appropriately
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications	caregiver performs medical/rehabilitation treatments with adequate competence
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 ; 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.	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
No orders Advance Directive:No Advance Directive on File	patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule
PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M2102f - Patient Supervision, meal preparation, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, heartburn/indigestion, limited strength, limited range of motion, pain radiating to arms/legs, balance deficit, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, red/tender pressure points, #1 - Non-Observable Surgical Wound - Anterior Right Thigh - Femur fracture with wound vac	patient is adequately supervised
PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Thigh - Femur fracture with wound vac: No orders, cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care, wound vacuum: Intact, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals	meal preparation is available to patient for all meals
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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence	

PT Careplans	PT Goals
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Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/08/2026

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Amanda Steber			HomeCentris Healthcare LLC		
3027 Westfield Avenue,			10 Crossroads Drive, Suite 102		
Baltimore, MD 21214-			Owings Mills, MD 21117-8284		
410-736-1066			410-321-8448		
			1487113239		
PT WK2: 1 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26) ,WK4: 1 (05/24/26-05/30/26) ,WK5: 1 (05/31/26-06/06/26) ,WK6: 1 (06/07/26-06/13/26) ,WK7: 1 (06/14/26-06/20/26) ,WK8: 1 (06/21/26-06/27/26) ,WK9: 1 (06/28/26-07/04/26)			PATIENT-STATED GOAL: I want to walk again and get rid of my sciatic pain		
PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170I1 - Walk 10 Feet, GG0170P1 - Picking Up Object, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170M1 - 1 - Step (curb), GG0170S1 - Wheel 150 feet, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand			GOALS		
PROCEDURES: wheelchair training, home exercise program: Supine hip flexion, straight leg raise, hip abduction. Sidelying hip abduction, prone knee flexion, hip extension, up on elbows, up on hands. Sitting knee extension, ankle pumps, equipment training, transfers training			patient/caregiver recalls		
TEACH PATIENT/CAREGIVER: * 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 - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, 1 - Step (curb) - 02. Substantial/maximal assistance, 12 Steps - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Car Transfer - 05. Setup or clean-up assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent			* 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 - 05. Setup or clean-up assistance		
			Chair to Bed to Chair - 05. Setup or clean-up assistance		
			Toilet Transfer - 05. Setup or clean-up assistance		
			Wheel 50 ft w 2 Turns - 06. Independent		
			Wheel 150 feet - 06. Independent		
			1 - Step (curb) - 02. Substantial/maximal assistance		
			12 Steps - 02. Substantial/maximal assistance		
			4 Steps - 02. Substantial/maximal assistance		
			Car Transfer - 05. Setup or clean-up assistance		
			Picking Up Object - 02. Substantial/maximal assistance		
			Walk 10 Feet - 02. Substantial/maximal assistance		
			Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance		
			Walk 150 Feet - 02. Substantial/maximal assistance		
			Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance		
			Oral Hygiene - 06. Independent		
			Toileting Hygiene - 06. Independent		
			Shower/Bathe Self - 02. Substantial/maximal assistance		
			Lower Body Dressing - 06. Independent		
			Don/Doff Footwear - 06. Independent		
			Upper Body Dressing - 06. Independent		

Signature of Physician:	Date
	PAGE 3 of 3
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