Home Health Certification and Plan of Care

Order ID: 1150/19020

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
AA00002568	05/23/2026	From: 05/23/2026 To: 07/21/2026	26184	217058

6. Patient's Name and Address
Virgiel Hayden
7000 Rudisill Court APt 2B,
WINDSOR MILL, MD 21244-
443-871-7327

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 01/24/1955 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S72.141D	Displ intertroch fx r femur subs for clos fx w routn heal	05/23/26

13. ICD	Other Pertinent Diagnoses	Date
I11.0	Hypertensive heart disease with heart failure	05/23/26
I50.22	Chronic systolic (congestive) heart failure	05/23/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	05/23/26
F32.A	Depression unspecified	05/23/26
E78.2	Mixed hyperlipidemia	05/23/26
E55.9	Vitamin D deficiency unspecified	05/23/26
I25.2	Old myocardial infarction	05/23/26
I42.9	Cardiomyopathy unspecified	05/23/26
K74.60	Unspecified cirrhosis of liver	05/23/26
D50.9	Iron deficiency anemia unspecified	05/23/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/23/26
R13.12	Dysphagia oropharyngeal phase	05/23/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	05/23/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	05/23/26
Z87.440	Personal history of urinary (tract) infections	05/23/26
Z91.81	History of falling	05/23/26

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

ASPIRIN 81 MG tablet by mouth one time a day for DVT prophylaxis
ATORVASTATIN 80 MG tablet by mouth at bedtime for HLD
BENZONATATE 100 MG capsule by mouth every 8 hours as needed for cough for 3 days
CLOPIDOGREL 75 MG tablet by mouth one time a day for DVT prophylaxis
FUROSEMIDE 40 MG tablet by mouth one time a day for CHF
LACTULOSE 30 ml by mouth one time a day for constipation
LOSARTAN POTASSIUM 100 MG tablet by mouth one time a day for HTN Hold for SBP<100 or HR<55
MELATONIN 3 MG tablet by mouth at bedtime for insomnia
METOPROLOL 25 MG tablet by mouth one time a day for HTN hold for HR<55
POTASSIUM 40 mEq by mouth at bedtime
TYLENOL 500 MG mg by mouth every 8 hours as needed for pain

14. DME and Supplies:
cane, walker

15. Safety Measures:
standard precautions, fall precautions, bathroom safety, ambulates with device

16. Nutrition:
fluid restriction, cardiac diet

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Walker,

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., 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: 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
SN:patient will be responsible for managing treatment
PT: family/caregiver will be responsible for managing treatment
OT:patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Displ intertroch fracture r femur subsequent 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 71-year-old female with a significant past medical history of cerebrovascular accident (CVA), heart failure with preserved ejection fraction (HFpEF), coronary artery disease (CAD), hypertension (HTN), and mood disorder. The patient was recently hospitalized following a fall that resulted in a right hip fracture requiring surgical repair with intramedullary nailing. Her hospitalization was further complicated by a cardiac arrest, followed by a stay in a subacute rehabilitation facility prior to discharge home. The patient is considered homebound due to hypertension, recent right hip fracture, impaired mobility, and an unsteady gait, which significantly increase her risk for falls when leaving the home. She ambulates with a rolling walker and requires human assistance for safe community mobility. During the assessment, the patient was alert and oriented to person and place and intermittently to time (A&O x2-3), with noted forgetfulness. Skin assessment revealed warm, dry, and intact skin without evidence of breakdown. Respiratory assessment was unremarkable, with respirations even and unlabored and no signs or symptoms of shortness of breath. The patient denied pain at the time of the visit. Physical therapy evaluation was completed. Prior to hospitalization, the patient was independent with ambulation and only occasionally utilized a single-point cane. Current assessment demonstrates a significant decline in functional mobility and strength. Manual muscle testing revealed right lower extremity strength of 3-/5 and left lower extremity strength of 3/5. The patient requires contact guard assistance for transfers and short-distance ambulation using a rolling walker. Functional mobility is limited by decreased right hip and knee range of motion, including inability to flex the right hip beyond approximately 70 degrees and right knee flexion limited to approximately 80 degrees. The patient was instructed in an initial home exercise program consisting of seated bilateral lower extremity therapeutic exercises and was encouraged to ambulate daily two to three times as tolerated. Skilled physical therapy services are indicated to improve lower extremity strength, balance, endurance, range of motion, safety awareness, and overall functional mobility with the goal of maximizing independence and facilitating a return to her prior level of function. Occupational therapy evaluation was also completed. Assessment revealed bilateral upper extremity weakness with strength measured at 4-/5. The patient currently requires minimal assistance with upper and lower body dressing tasks and assistance with bathing at the sink side. She requires contact guard assistance for sit-to-stand transfers and toilet transfers and benefits from verbal cueing for proper limb placement and transfer techniques to ensure safety. Deficits in strength, balance, endurance, and functional mobility continue to impact her ability to safely perform activities of daily living independently. Skilled occupational therapy services are recommended to address ADL retraining, upper extremity strengthening, transfer training, safety awareness, energy conservation techniques, and caregiver education to improve functional independence and reduce fall risk. The patient was educated regarding fall prevention strategies, safe use of assistive devices, adherence to prescribed home exercise programs, proper transfer techniques, and the importance of seeking assistance during mobility activities to prevent injury. The plan of care includes continued skilled nursing assessment and monitoring, as well as ongoing physical and occupational therapy services to improve strength, mobility, balance, functional independence, and overall safety within the home environment.
 Date of Order 05/23/2026 Orders Physician Face-to-Face Date: 05/13/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat, hha-adl's due to Displ intertroch fracture r femur subsequent for closed

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/23/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Arthur Harrow
2435 W Belvedere Ave
Baltimore, MD 21215
PHONE: 4106016840 FAX: 14106014029 NPI: 1114911955

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 : 05/13/2026

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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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 Harrow, Arthur

SN Careplans

SN WK1: 1 (05/23/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK6: 1 (06/21/26-06/27/26) ,WK7: 1 (06/28/26-06/30/26)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 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, 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, D0700 - Social Isolation, lightheadedness, M1033 - Unintentional Weight Loss, M1400 - Dyspnea, constipation, muscle weakness, headache, B0200 - Hearing Deficit, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit

PROCEDURES: cough/deep breathing exercises, incentive spirometer, swallowing exercises, monitor intake & output, coordinate/arrange resources for vision-impaired, coordinate/arrange long-term socialization activities, 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 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, * strategies to increase caloric intake, related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 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, * strategies to increase socialization, related medication(s) purpose, schedule

SN Goals

PATIENT-STATED GOAL: To get well and go outside 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/caregiver recalls
* strategies to increase caloric intake
* 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
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/23/2026

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PT WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK6: 1 (06/21/26-06/27/26) ,WK7: 1 (06/28/26-06/30/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed. Upgrade as tolerated, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: 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, 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PATIENT-STATED GOAL: To be able to walk without help

GOALS
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

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

Car Transfer - 05. Setup or clean-up assistance

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

OT Careplans

OT WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK6: 1 (06/21/26-06/27/26) ,WK7: 1 (06/28/26-06/30/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing

PROCEDURES: Therapeutic exercise: clinician will describe procedure at time of visits, Patient/caregiver recalls related purpose and schedule of medications: Medications review, home exercise program: Home exercise program to constant of using water bottles, dumbbells or theraband for upper extremity., work simplification/energy conservation, transfers training: Transfer 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, * 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching 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 do more things

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 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

Eating - 06. Independent

HHA Careplans

HHA WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26) ,WK5: 1 (06/14/26-06/20/26) ,WK6: 1 (06/21/26-06/27/26) ,WK7: 1 (06/28/26-06/30/26)

PROCEDURES: assist with bathing: Bathe sink and/or shower using tub bench/chair, assist with toilet transferring, assist with toileting hygiene, assist with transferring, assist with mobility, assist with infection control: Change linen, assist with fall prevention, assist with grooming: Assist with lotion body and using deodorant, assist with lower body dressing, assist with upper body dressing

HHA Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/23/2026