Home Health Certification and Plan of Care

Order ID: 1150/19231

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2JP3XK9CU95	06/04/2026	From: 06/04/2026 To: 08/02/2026	26523	217058

6. Patient's Name and Address

Denise Joyner
101 N. Schroder Ave Apt 229,
Baltimore, MD 21223-
443-766-5736

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 02/10/1963 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S82.434D	Nondisp oblique fx shaft of r fibula 7thD	06/04/26

13. ICD	Other Pertinent Diagnoses	Date
L89.611	Pressure ulcer of right heel stage 1	06/04/26
I10.	Essential (primary) hypertension	06/04/26
J44.9	Chronic obstructive pulmonary disease unspecified	06/04/26
E78.5	Hyperlipidemia unspecified	06/04/26
D64.9	Anemia unspecified	06/04/26
M17.11	Unilateral primary osteoarthritis right knee	06/04/26
M19.011	Primary osteoarthritis right shoulder	06/04/26
G62.9	Polyneuropathy unspecified	06/04/26
F25.9	Schizoaffective disorder unspecified	06/04/26
F31.9	Bipolar disorder unspecified	06/04/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/04/26
M81.0	Age-related osteoporosis w/o current pathological fracture	06/04/26
M25.551	Pain in right hip	06/04/26
G89.29	Other chronic pain	06/04/26
F11.21	Opioid dependence in remission	06/04/26
E55.9	Vitamin D deficiency unspecified	06/04/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	06/04/26
Z79.82	Long term (current) use of aspirin	06/04/26
Z79.891	Long term (current) use of opiate analgesic	06/04/26
Z91.81	History of falling	06/04/26

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

ASPIRIN Chewable 81 mg / 1 Tablet by mouth one time a day for prophylaxis
Acetaminophen - Acetaminophen 325 mg/tablet / Give 2 tablet by mouth every 6 hours as needed for arthritis pain
Atorvastatin Calcium - Atorvastatin Calcium 40 mg / 1 Tablet by mouth at bedtime for hyperlipidemia
Buspirone Hydrochloride - Buspirone Hydrochloride 5 mg/tablet / Give 2 Tablet by mouth twice a day for Anxiety
DEPAKOTE Delayed Release 500 mg/tablet / Give 2 tablet by mouth two times a day for schizoaffective disorder
Ergocalciferol - Ergocalciferol 1.25 MG (50000 UT) / 1 Capsule by mouth once a day every Sat for Supplement
Famotidine - Famotidine 20 mg/tablet / Give 0.5 tablet by mouth twice a day for GERD
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) mg / 1 Tablet by mouth in the morning for abnormal Labs
GABAPENTIN 300 mg capsule by mouth twice a day for neuropathic pain
Melatonin - Melatonin 3 mg / 1 Capsule by mouth at bedtime for sleep
Miralax - Polyethylene Glycol 3350 Packet 17 GM / Give 1 packet by mouth twice a day for bowel regimen stir and dissolve in any 4 - 8 ounces of non carbonated beverage
Multiple Vitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox Give 1 Tablet by mouth once a day for Supplement
OXYCODONE 5 mg / 1 Tablet by mouth every 6 hours as needed for pain management
Sennosides - Senna Give 2 tablet by mouth two times a day for bowel regimen
Trazodone Hydrochloride - Trazodone Hydrochloride 50 mg / 1 Tablet by mouth at bedtime for insomnia and anxiety
Lidocaine Patch - Lidocaine 5 % / Apply to Right posterior shoulder topically one time a day for pain and remove per schedule

14. DME and Supplies:
walker, wheelchair

15. Safety Measures:
walker precautions, wheelchair precautions, standard precautions, fall precautions, ambulates with device,

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
Haldol

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Up As Tolerated

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: 4. Always, BEHAVIORAL ISSUES: 6. Delusional, hallucinatory, or paranoid behavior, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

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
patient will be responsible for managing treatment

Homebound status:
Due to diagnosis of Nondisplaced oblique fracture of shaft of right fibula, 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:
Patient is a 63-year-old female admitted to home health services following a recent hospitalization and 10-week rehabilitation stay related to a fall resulting in a right distal fibular fracture. Past medical history is significant for hypertension, COPD, right heel pressure ulcer, osteoarthritis of the right hip and knee, TIA, hyperlipidemia, polyneuropathy, schizoaffective disorder, bipolar disorder, chronic pain, opioid dependence, recurrent falls, weakness, and gait abnormalities. Patient is alert and oriented 3, with skin noted to be warm and dry, and an area present on the right heel. She lives alone in an elevator-accessible senior apartment with two cats, and her granddaughters assist as needed. Patient ambulates approximately 30 feet indoors with a rolling walker and increased trunk flexion and also utilizes a wheelchair for mobility. Transfers to bed, toilet, and wheelchair, as well as bed mobility, require supervision. Functional assessment revealed decreased strength, impaired balance, unsteady gait, reduced endurance, and increased fall risk, as evidenced by a Tinetti score of 13/28. Patient reports that her previous fall may have been related to excessive sedation from Seroquel, resulting in her remaining on the floor for four days before being able to call for assistance. She recently obtained a tub seat after difficulty exiting the bathtub independently. Patient tolerated therapeutic exercises including supine hip flexion, bridging, hooklying rotation, straight leg raises, hip abduction, knee extension, and ankle pumps. Skilled nursing, physical therapy, and occupational therapy services are medically necessary to address strengthening, gait training, transfer safety, ADL performance, adaptive equipment training, functional mobility, homemaking tasks, safety awareness, and fall prevention to maximize independence and reduce the risk of further functional decline or hospitalization. Patient is considered homebound due to significant effort required to leave the home, dependence on assistive devices and human assistance, and high fall risk.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> <p

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/04/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Kristie E Khatibi
29 South Paca St
Baltimore, MD 21201
PHONE: 6672142100 FAX: 14106851973 NPI: 1437888955

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 : 05/26/2026

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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class="MsoNoSpacing">06/04/2026
 Order<o:p></o:p> Physician Face-to-Face Date: 05/26/2026
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Nondisplaced oblique fracture of shaft of right fibula, 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:<o:p></o:p> OT Eval Notes:<o:p></o:p> Physician: Khatibi, Kristie E

SN Careplans

SN WK1: 1 (06/04/26-06/06/26) ,WK2: 1 (06/07/26-06/13/26) ,WK3: 1 (06/14/26-06/20/26) ,WK4: 1 (06/21/26-06/27/26) ,WK5: 1 (06/28/26-07/04/26) ,WK6: 1 (07/05/26-07/11/26) ,WK7: 1 (07/12/26-07/18/26) ,WK8: 1 (07/19/26-07/25/26)

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), 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 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; 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:MOLST

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M1745 - Behavioral Issues, M2020 - Oral Med Management, D0700 - Social Isolation, M1033 - Exhaustion, M1400 - Dyspnea, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit, obesity

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange resources for vision-impaired, coordinate/arrange long-term socialization activities

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, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, 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

SN Goals

PATIENT-STATED GOAL: Able to walk and keep my balance

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
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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/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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/04/2026

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medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule

PT Careplans

PT WK1: 1 (06/05/26-06/06/26)

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: Stretching to right ankle: Remove ankle brace and stretch into dorsiflexion, plantarflexion, circumduction, home exercise program: Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, 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 - 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: To be able to exit the building using my walker

GOALS
Toilet Transfer - 06. Independent

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 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 (06/07/26-06/13/26) ,WK4: 1 (06/21/26-06/27/26) ,WK6: 1 (07/05/26-07/11/26) ,WK8: 1 (07/19/26-07/25/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, 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: cough/deep breathing exercises, incentive spirometer, home exercise program: 16 oz water bottle: bilateral shoulder flex, chest presses horizontal abd add bicep curls 2x10 reps, equipment training, work simplification/energy conservation, transfers training: Toilet, tub

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 - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Not to fall 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

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

HHA Careplans

HHA WK2: 1 (06/07/26-06/13/26) ,WK3: 1 (06/14/26-06/20/26) ,WK4: 1 (06/21/26-06/27/26) ,WK5: 1 (06/28/26-07/04/26) ,WK6: 1 (07/05/26-07/11/26) ,WK7: 1 (07/12/26-07/18/26)

PROCEDURES: assist with bathing, assist with transferring, assist with mobility, assist with feeding/eating, assist with seizure precautions prn, assist with infection control, assist with fall prevention, assist with assistive devices prn, assist with grooming, assist with lower body dressing, assist with upper body dressing

HHA Goals

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/04/2026