

Home Health Certification and Plan of Care				Order ID: 1150/19405	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
100047391		06/05/2026		From: 06/05/2026 To: 08/03/2026	
				4. Medical Record No.	
				26458	
				5. Provider No.	
				217058	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Kathryn Mokwa 8480 Ice Crystal Drive Unit N, Laurel, MD 20723- 412-951-9905			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
05/06/1940			Female		
11. ICD		Principal Diagnosis		Date	
S22.000D		Wedge comprsn fx unsp thor vert subs for fx w routn heal		06/05/26	
13. ICD		Other Pertinent Diagnoses		Date	
S40.012D		Contusion of left shoulder subsequent encounter		06/05/26	
I48.0		Paroxysmal atrial fibrillation		06/05/26	
I11.9		Hypertensive heart disease without heart failure		06/05/26	
K22.70		Barrett's esophagus without dysplasia		06/05/26	
N81.4		Uterovaginal prolapse unspecified		06/05/26	
I35.1		Nonrheumatic aortic (valve) insufficiency		06/05/26	
I35.0		Nonrheumatic aortic (valve) stenosis		06/05/26	
K59.09		Other constipation		06/05/26	
E03.9		Hypothyroidism unspecified		06/05/26	
G47.33		Obstructive sleep apnea (adult) (pediatric)		06/05/26	
F41.9		Anxiety disorder unspecified		06/05/26	
E87.1		Hypo-osmolality and hyponatremia		06/05/26	
D62.		Acute posthemorrhagic anemia		06/05/26	
E78.2		Mixed hyperlipidemia		06/05/26	
K21.9		Gastro-esophageal reflux disease without esophagitis		06/05/26	
Z96.653		Presence of artificial knee joint bilateral		06/05/26	
14. DME and Supplies:			15. Safety Measures:		
walker, hand held shower, grab bars, bath bench, cane			walker precautions, transfer with assist, standard precautions, smoke detectors , medication safety, fall precautions, cardiac precautions, bleeding precautions, bathroom safety, anticoagulant precautions, ambulates with device, ambulates with assistance, activity supervision		
16. Nutrition:			17. Allergies:		
fluid restriction			lisinopril		
18.A. Functional Limitations			18.B. Activities Permitted		
Ambulation, Endurance			Walker, Up As Tolerated		
19. Mental & Psychosocial 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: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No		
20. Prognosis:			fair		
22. A Rehabilitation Potential:			22.B.Discharge Plans		
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.			family/caregiver will be responsible for managing treatment		
Homebound status:			Due to diagnosis of Wedge compression fracture of unspecified thoracic vertebra, 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>Patient is an 86-year-old female with a significant medical history of paroxysmal atrial fibrillation, hypertension, chronic anticoagulation therapy, recent left axillary hematoma with supratherapeutic INR, T7 compression fracture, and generalized deconditioning. The patient was recently hospitalized at Howard County General Hospital for approximately six days after developing severe pain, swelling, and discoloration of the left upper extremity. Prior to hospitalization, the patient had been prescribed a steroid by her primary care physician for back pain. During hospitalization, laboratory evaluation revealed a significantly elevated INR while the patient was receiving warfarin (Coumadin), and she was found to have developed a large left axillary hematoma, which may have been related to an interaction between the steroid medication and warfarin therapy. <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-Warfarin">Warfarin</mh> was discontinued immediately, and the patient was transitioned to apixaban (Eliquis) for anticoagulation management. The steroid medication was also discontinued. In addition, the patient was diagnosed with hyponatremia during hospitalization and was started on sodium supplementation along with a fluid restriction of 1.5 liters per day. The patient was discharged home with plans for follow-up appointments with her primary care physician and cardiologist over the next two weeks. Upon home health assessment, the patient was alert and oriented and demonstrated understanding of her current medication regimen, including anticoagulation therapy, sodium supplementation, fluid restrictions, and pain management medications. The patient currently utilizes oxycodone and acetaminophen for pain control. Vital signs were assessed and found to be stable. The patient denied additional questions or concerns at the time of the visit. Although the patient lives alone, her children are rotating schedules to provide around-the-clock supervision and assistance during her recovery period. A skilled physical therapy evaluation was completed following referral for rehabilitation after hospitalization from 05/27/2026 through 05/29/2026 for left upper extremity hematoma and pain. Assessment revealed persistent left shoulder pain and significantly limited		
23. Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT		
Electronically Signed by Messick, Charles RN on 06/05/2026					
24. Physician's Name and Address			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.		
Lauren Psoras 6740 Alexander Bell Dr Ste 300 Columbia, MD 21046 PHONE: 4105640000 FAX: 14105640032 NPI: 1003651761			F2F date : 05/27/2026		
27. Attending Physician's Signature and Date Signed			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.		
: Date of physician last face-to-face			PAGE 1 of 3		

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functional use of the left upper extremity secondary to a large axillary hematoma with associated ecchymosis. The patient also reports thoracic pain related to a newly diagnosed T7 compression fracture. Additional findings include bilateral lower extremity weakness, generalized deconditioning, impaired balance, and reduced activity tolerance. Functional mobility assessment demonstrated impaired bed mobility, transfers requiring a rolling walker with minimal assistance for safety, and antalgic gait characterized by decreased weight-bearing tolerance, impaired balance, and increased fall risk during household ambulation. These impairments substantially limit the patient's ability to safely perform daily activities and increase her risk for falls, injury, and further functional decline. Education was provided regarding medication compliance, anticoagulation precautions, adherence to prescribed fluid restrictions, sodium supplementation, fall prevention strategies, energy conservation techniques, and the importance of attending scheduled follow-up appointments with her healthcare providers. The patient was instructed to monitor for and promptly report signs of bleeding, increased bruising, worsening pain, dizziness, shortness of breath, chest pain, increased swelling, neurological changes, or any decline in functional status. The patient verbalized understanding of all education provided. Skilled home health services remain medically necessary for ongoing assessment and monitoring of the patient's recovery from left axillary hematoma, management of anticoagulation therapy, monitoring of hyponatremia and fluid restrictions, pain management, and continued patient and caregiver education. Skilled physical therapy services are required to address lower extremity weakness, impaired balance, gait deficits, decreased endurance, impaired transfers, limited functional mobility, and fall risk through therapeutic exercise, balance training, gait training, transfer training, home exercise program instruction, and caregiver education. The goal of care is to safely restore the patient's prior level of function, maximize independence within the home, reduce fall risk, and prevent rehospitalization.

Date of Order: 06/05/2026

Physician Face-to-Face Date: 05/27/2026

Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hhadi's due to Wedge compression fracture of unspecified thoracic vertebra, subsequent encounter for 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

PT Eval Notes: 1 - SOC - SN Notes: soc

Physician: Psoras, Lauren

SN Careplans

SN WK1: 1 (06/05/26-06/06/26) ,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)

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 > 10

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

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, 9. Other risk(s) not listed in 1- 8

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:Patient states she has an AD; requested copy for our records.

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, coughing, M1400 - Dyspnea, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, dependent edema, abn cholesterol > 200 mg/dL, abnormal blood pressure, abnormal thyroid <> 0.40 - 4.50 mIU/mL, constipation, poor muscle tone, muscle weakness, limited strength, limited range of motion, limited endurance, balance deficit, headache, Pain Effect on Sleep, Pain Interference with ADLs, difficulty sleeping, daytime fatigue, loss of appetite, discolored patches of skin, bruising/discoloration

SN Goals

PATIENT-STATED GOAL: To get back to my normal self

GOALS

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

- * 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

- * 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 is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/05/2026

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PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision 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, * 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 is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence	
PT Careplans PT 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) PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170O1 - 12 Steps, GG0130F1 - Upper Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, GG0170D1 - Sit to Stand, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer PROCEDURES: B LE mm strengthening: 1, Medication Review-: Patient verbalized understanding of current prescriptions, dosages, and schedule. No reported issues with adherence, side effects, or confusion at this time., home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation., gait training/stair training, transfers training TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent	PT Goals PATIENT-STATED GOAL: To get my endurance back GOALS Chair to Bed to Chair - 06. Independent Toilet Transfer - 06. Independent Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance 1 - Step (curb) - 05. Setup or clean-up assistance Sit to Stand - 06. Independent Car Transfer - 06. Independent Walk 10 Feet - 05. Setup or clean-up assistance Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance Walk 150 Feet - 05. Setup or clean-up assistance 4 Steps - 05. Setup or clean-up assistance 12 Steps - 05. Setup or clean-up assistance Picking Up Object - 05. Setup or clean-up assistance Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Shower/Bathe Self - 06. Independent Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Upper Body Dressing - 06. Independent

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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