Home Health Certification and Plan of Care

Order ID: 1150/20071

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
68305152	06/23/2026	From: 06/23/2026 To: 08/21/2026	27326	217058

6. Patient's Name and Address

Linda Peacock
605 Jackson Blvd,
BEL AIR, MD 21014-
443-567-6336

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 04/12/1943 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S72.141D	Displ intertroch fx r femur subs for clos fx w routn heal	06/23/26

13. ICD	Other Pertinent Diagnoses	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	06/23/26
I50.9	Heart failure unspecified	06/23/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/23/26
N18.32	Chronic kidney disease stage 3b	06/23/26
D63.1	Anemia in chronic kidney disease	06/23/26
G30.9	Alzheimer's disease unspecified	06/23/26
F02.811	Dem in other dis classd elswhr unsp severt with agitation	06/23/26
F02.83	Dem in other dis classd elswhr unsp sev with mood distrb	06/23/26
F32.A	Depression unspecified	06/23/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	06/23/26
D50.9	Iron deficiency anemia unspecified	06/23/26
E78.5	Hyperlipidemia unspecified	06/23/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/23/26
Z86.16	Personal history of COVID-19	06/23/26
Z87.01	Personal history of pneumonia (recurrent)	06/23/26
Z95.5	Presence of coronary angioplasty implant and graft	06/23/26
Z91.81	History of falling	06/23/26

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

TYLENOL 650 mg by mouth every 6 hours PRN
Toprol-Xl - Metoprolol Succinate 12.5 mg by mouth 1 time daily
REMERON 7.5 mg by mouth nightly
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 mg by mouth 1 time daily
BUSPAR 5 mg by mouth 2 times daily
ZESTRIL 2.5 mg by mouth 1 time daily
Enoxaparin Sodium - Enoxaparin Sodium 40mg/0.4ml subcutaneous once a day Anticoagulant for 8 days.

14. DME and Supplies:

wheelchair, walker, rolling walker, hospital bed, grab bars, commode, cane, bath bench

15. Safety Measures:

wheelchair precautions, walker precautions, transfer with assist, standard precautions, medication safety, hip precautions, hand rails, fall precautions, bleeding precautions, bathroom safety, anticoagulant precautions, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

regular, ,

17. Allergies:

ofloxacin erythromycin

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Up As Tolerated,

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions!6. Delusional, hallucinatory, or paranoid behavior, 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: 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

SN: patient will be responsible for managing treatment PT: family/caregiver will

Homebound status:

Due to diagnosis of Displaced intertrochanteric fracture 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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/23/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Stephanie Davis
3400 Box Hill Corporate Center Dr
Abingdon, MD 21009
PHONE: 1-800-777-7904 FAX: kaiser NPI: 1013976091

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 : 06/18/2026

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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Clinical Condition Requiring Homecare:

The patient is an 83-year-old female admitted to home health following a mechanical fall resulting in a right intertrochanteric hip fracture, status post open reduction and internal fixation (ORIF), with weight bearing as tolerated on the right lower extremity. Her past medical history is significant for severe Alzheimer's dementia with behavioral disturbances, iron deficiency anemia, hypertension, type 2 diabetes mellitus, heart failure, chronic kidney disease, coronary artery disease, hyperlipidemia, depression, gastroesophageal reflux disease, pneumonia, and other comorbidities. The patient is alert and oriented to self only, with intermittent hallucinations, agitation, and significant cognitive impairment that limits her ability to participate in care. She resides with her sister, who is her primary caregiver and power of attorney, and her brother-in-law in a two-story home. Prior to hospitalization, the patient was independently ambulatory without an assistive device, managed transfers and bed mobility independently, negotiated stairs, and required assistance only with showering. The surgical incision was clean, dry, intact, and left open to air without signs of infection. The patient is receiving enoxaparin (Lovenox), which is administered by her sister, who demonstrated appropriate administration technique and participated in a comprehensive medication review. Physical therapy evaluation revealed profound functional decline, with the patient requiring maximal assistance for bed mobility, sit-to-stand and stand-pivot transfers, and ambulating only four small steps with a rolling walker due to weakness and cognitive deficits. Given the patient's advanced dementia, high fall risk, significant functional impairment, and the family's inability to safely manage her care at home, the therapist consulted with the home health nurse, Kaiser representatives, and the agency director. Based on these findings, emergency medical services (911) were activated to transport the patient to the hospital for evaluation with the anticipated plan for admission to an inpatient rehabilitation facility to improve safety and functional recovery.
<o:p></o:p> Date of Order<o:p></o:p> 06/23/2026<o:p></o:p> Physician Face-to-Face Date: 06/18/2026<o:p></o:p> Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing<o:p></o:p> 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> Physician: Davis, Stephanie

SN Careplans

SN WK1: 1 (06/23/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26) ,WK3: 1 (07/05/26-07/11/26) ,WK4: 1 (07/12/26-07/18/26) ,WK5: 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, 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.

SN Goals

PATIENT-STATED GOAL: To be able to use the stairs and get back to her room upstairs.

GOALS
patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* 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
* 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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
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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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M1700 - Cognition, D0160 - Depression, M1745 - Behavioral Issues, M2020 - Oral Med Management, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, balance deficit, Pain Interference with ADLs, swell/redness surround. skin, #1 - Observable Surgical Wound - Anterior Right Hip - LOTA

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Right Hip - LOTA: LOTA but cover with a dry gauze if drainage occurs., coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion

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, * how to keep home safe for patient with dementia coping strategies for the caregiver*, 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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

* 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
* 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
* 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

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

PT Careplans

PT WK1: 1 (06/23/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26) ,WK3: 2 (07/05/26-07/11/26) ,WK4: 1 (07/12/26-07/18/26) ,WK5: 1 (07/19/26-07/25/26) ,WK6: 1 (07/26/26-08/01/26) ,WK7: 1 (08/02/26-08/08/26) ,WK8: 1 (08/09/26-08/15/26) ,WK9: 1 (08/16/26-08/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170R1 - Wheel 50 ft w 2 Turns, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170S1 - Wheel 150 feet, GG0170D1 - Sit to Stand, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, 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, GG0170F1 - Toilet Transfer

PROCEDURES: Bed mobility : Ed pt amd family on log rolling, sup<> sit transfers, Medication management : Review medication with caregiver, wheelchair training, home exercise program: Supine ankle pumps, heel slides hamstring stretch, supine tes AA as needed for abd add, saq, , seated laq , hip flexion, heel raises, DF with AA as needed, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Walk 10 Feet - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Wheel 50 ft w 2 Turns - 06. Independent, Car Transfer - 05. Setup or clean-up assistance, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: Pt unable to state, per family, to get her to walk again go up steps and do what she used to do

GOALS
1 - Step (curb) - 05. Setup or clean-up assistance

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 - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Wheel 50 ft w 2 Turns - 06. Independent

Car Transfer - 05. Setup or clean-up assistance

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
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