Home Health Certification and Plan of Care

Order ID: 1150/20082

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2PK0Y94RG42	06/24/2026	From: 06/24/2026 To: 08/22/2026	21853	217058

6. Patient's Name and Address

Ovalee Barefoot
22 HADDINGTON ROAD,
LUTHERVILLE TIMONIUM, MD 21093-
410-294-6923

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 11/15/1931 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
S72.002D	Fx unsp part of nk of l femr subs for clos fx w routn heal	06/24/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	06/24/26
I11.0	Hypertensive heart disease with heart failure	06/24/26
I50.32	Chronic diastolic (congestive) heart failure	06/24/26
I48.0	Paroxysmal atrial fibrillation	06/24/26
E53.8	Deficiency of other specified B group vitamins	06/24/26
C61.	Malignant neoplasm of prostate	06/24/26
D63.0	Anemia in neoplastic disease	06/24/26
G89.3	Neoplasm related pain (acute) (chronic)	06/24/26
E78.49	Other hyperlipidemia	06/24/26
R13.10	Dysphagia unspecified	06/24/26
D47.2	Monoclonal gammopathy	06/24/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/24/26
G47.00	Insomnia unspecified	06/24/26
K59.00	Constipation unspecified	06/24/26
Z86.718	Personal history of other venous thrombosis and embolism	06/24/26
Z87.440	Personal history of urinary (tract) infections	06/24/26
Z79.01	Long term (current) use of anticoagulants	06/24/26
Z95.828	Presence of other vascular implants and grafts	06/24/26
Z91.81	History of falling	06/24/26

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

Lipitor - Atorvastatin Calcium eq 20 mg base 1 Tablet by mouth in the evening Start: 1/23/26
Toprol Xl - Metoprolol Tartrate 100 mg / 1 Tablet by mouth twice a day Start: 1/25/26 Admin Instructions: DO NOT crush tablet.
Tylenol - Acetaminophen 650 mg / 1 Tablet by mouth every 6 hours as needed PRN Reason: mild pain (1-3) Start: 1/20/26 Admin Instructions: DO NOT EXCEED 4 grams Acetaminophen per day
Amiodarone - Amiodarone Hydrochloride 200 by mouth twice a day Take 1 tablet AM and 1 tab, PM
Lasix - Furosemide 20 mg by mouth once a day Start: 1/24/26 dose changed from 40mg to 20mg by cardiology Feb 18th 2026 per daughter
Pradaxa - Dabigatran Etexilate Mesylate 150 mg 1 tablet by mouth twice a day Blood thinner

14. DME and Supplies:

rolling walker, hand held shower, bath bench, grab bars, walker, cane, 4 wheeled walker

15. Safety Measures:

walker precautions, smoke detectors , medication safety, fall precautions, bleeding precautions, ambulates with device, ambulates with assistance, hip precautions, supervision at all times, transfer with assist, standard precautions, bathroom safety, activity supervision

16. Nutrition:

low sodium

17. Allergies:

NKA

18.A. Functional Limitations

Endurance, Bowel/Bladder Incontinence, Ambulation, Hearing

18.B. Activities Permitted

Cane, Up As Tolerated, Exercises Prescribed, 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: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: good

22. A Rehabilitation Potential:

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.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Fracture of unspecified part of neck of left 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:

Patient is a 94-year-old male admitted to home health services for skilled nursing, physical therapy, and occupational therapy following recent hospitalization and subsequent subacute rehabilitation for a left femoral neck fracture status post left hip hemiarthroplasty performed on 04/09/2026. Skilled services are medically necessary for comprehensive nursing assessment, disease process management, medication reconciliation and education, postoperative monitoring, anemia surveillance, fall prevention, and rehabilitation to restore functional mobility and independence. The patient has a significant past medical history including congestive heart failure (CHF), atrial fibrillation, hypertension, deep vein thrombosis status post inferior vena cava (IVC) filter placement, monoclonal gammopathy of uncertain significance (MGUS), prostate cancer, recurrent urinary tract infections, vitamin B12 deficiency, osteoarthritis, hearing impairment, history of right gluteal cellulitis, recurrent falls, and recent symptomatic anemia requiring transfusion of one unit of packed red blood cells. He is currently awaiting gastroenterology consultation for further evaluation of anemia and will continue follow-up with hematology and his primary care provider. The patient resides with his family in a multi-level home and currently stays in the basement due to impaired mobility following surgery. He is alert, oriented, pleasant, and cooperative throughout the assessment. He denies pain during today's visit as well as dizziness, presyncope, headache, vision changes, chest pain, palpitations, or shortness of breath. Respirations are even and unlabored on room air without signs of respiratory distress. Cardiopulmonary assessment revealed no evidence of acute CHF exacerbation or other acute abnormalities. The patient is recovering appropriately from his left hip hemiarthroplasty with no signs or symptoms of postoperative infection, impaired wound healing, or other surgical complications observed during today's assessment. A comprehensive Start of Care nursing assessment and medication reconciliation were completed. Skilled nursing interventions included assessment of cardiopulmonary status, monitoring for signs and symptoms of CHF exacerbation, evaluation for postoperative complications, infection surveillance, medication management, and ongoing assessment of anemia. Patient and caregiver received education regarding medication adherence, bleeding precautions due to medical history and anticoagulation risk factors, fall prevention strategies, infection prevention, recognition of symptoms requiring physician notification, and indications for seeking emergency medical care. Hip precautions were reviewed

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/24/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Camille Tawil
1734 York Rd
Timonium, MD 21093
PHONE: 4102522273 FAX: 14103859393 NPI: 1144225053

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 : 06/01/2026

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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and reinforced, including the importance of consistent compliance and proper use of prescribed assistive devices. Education was also provided regarding adequate hydration, balanced nutrition to support healing, and the importance of maintaining all scheduled follow-up appointments, including gastroenterology, hematology, and primary care. Functional assessment demonstrates persistent mobility and self-care deficits following surgery. The patient presents with generalized lower extremity weakness, impaired balance, decreased functional endurance, altered gait mechanics with reduced step length, and impaired safety awareness, contributing to an increased risk for falls. Bed mobility requires supervision for safe positioning and transitional movements. Sit-to-stand, toilet, and functional transfers require contact guard to moderate assistance with verbal cueing for proper hand placement and body mechanics. The patient ambulates within the home using a rolling walker with contact guard assistance and continues to demonstrate decreased stability during household ambulation. Ongoing rehabilitation is required to improve lower extremity strength, balance, endurance, gait quality, transfer safety, and overall functional mobility. Occupational therapy assessment further revealed bilateral upper extremity weakness with manual muscle testing measuring approximately 4-/5 bilaterally, limiting performance of activities of daily living. The patient experiences difficulty completing bathing and lower body dressing tasks due to hip discomfort and postoperative limitations. He currently performs bathing primarily at the sink and has entered the shower only twice since returning home. The patient reports occasionally forgetting to maintain prescribed hip precautions during functional activities, requiring continued reinforcement and caregiver supervision to maximize safety and reduce the risk of reinjury or hip dislocation. The patient remains homebound due to recent left hip surgery, generalized weakness, impaired balance, decreased endurance, significant fall risk, and dependence on a rolling walker with caregiver assistance for safe mobility outside the home. Leaving the residence requires considerable and taxing effort. Skilled nursing services will continue for ongoing cardiopulmonary assessment, medication management, postoperative monitoring, surveillance for anemia, bleeding, recurrent urinary tract infections, infection, and CHF exacerbation, as well as continued patient and caregiver education. Physical therapy will continue to address strengthening, gait training, balance training, transfer training, endurance, and fall prevention to improve functional mobility and promote safe independence within the home. Occupational therapy will continue to focus on improving upper extremity strength, activities of daily living, transfer safety, energy conservation, adherence to hip precautions, and safe performance of self-care tasks. The patient tolerated today's assessment without complications, verbalized understanding of all education provided, and remains agreeable to the established plan of care. No immediate concerns or acute changes were identified at the completion of today's visit.
 Date of Order 06/24/2026 Orders Physician Face-to-Face Date: 06/01/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Fracture of unspecified part of neck of left 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
 1 - SOC - SN Notes: soc OT Eval Notes: PT Eval Notes:
 Physician Tawil, Camille

SN Careplans

SN WK1: 1 (06/24/26-06/27/26) ,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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, dependent edema, M1400 - Dyspnea, M1033 - Exhaustion, lightheadedness, urine retention, frequent urination, M1610 - Urinary Incontinence, swelling of affected area, muscle weakness, limited range of motion, limited strength, limited endurance, B0200 - Hearing Deficit, Pain Effect on Sleep, Pain Interference with ADLs, weak

SN Goals

PATIENT-STATED GOAL: Patient states he wants to return back to living independently;Patient states he wants to return back to living independently

GOALS
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
* 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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

caregiver administers and/or packages medications appropriately

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/24/2026

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hand grips, daytime fatigue, balance deficit, loss of appetite

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, 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, * urinary incontinence management including bladder training Kegel exercises skin care, 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 hearing-impaired including installing special fire-detector/CO2 alarms, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (06/24/26-06/27/26) ,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) ,WK6: 1 (07/26/26-08/01/26) ,WK7: 1 (08/02/26-08/08/26)

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, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair

PROCEDURES: B LE mm strengthening: 1, 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. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., 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 - 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, Car Transfer - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: To be able to walk safer at home

GOALS
Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

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

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

Car Transfer - 05. Setup or clean-up assistance

OT Careplans

OT WK1: 1 (06/24/26-06/27/26) ,WK3: 1 (07/05/26-07/11/26) ,WK4: 1 (07/12/26-07/18/26) ,WK5: 1 (07/19/26-07/25/26) ,WK6: 1 (07/26/26-08/01/26) ,WK7: 1 (08/02/26-08/08/26) ,WK9: 1 (08/16/26-08/22/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: Patient/caregiver recalls related purpose and schedule of medications: Medication Review, cough/deep breathing exercises, therapeutic exercises: Using dumbbells or therabands to perform bilateral upper extremity muscle strength exercises, transfers training, transfers training: Sit to stand and toliet transfer

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, Toilet Transfer - 06. Independent, 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, Patient will demonstrates improved bilateral upper extremity muscle strength from 4-/5 mmt to 4+/5 mmt to improve Adls and transfers safely

OT Goals

PATIENT-STATED GOAL: Wants to get better

GOALS
Toilet Transfer - 06. Independent

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

Signature of Physician:	Date
	PAGE 3 of 4
Optional Name/Signature of Nurse/Therapist:	Date
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Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Patient will demonstrates improved bilateral upper extremity muscle strength from 4-/5 mmt to 4+/5 mmt to improve Adls and transfers safely

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

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