Home Health Certification and Plan of Care

Order ID: 1150/20138

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
9DE7XJ8QV48	06/28/2026	From: 06/28/2026 To: 08/26/2026	27369	217058

6. Patient's Name and Address

Lois Kressig
1907 HIgh Point Rd,
FOREST HILL, MD 21050
410-255-6111

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 03/23/1955 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S72.144D	Nondisp intertroch fx r femur subs for clos fx w routn heal	06/28/26

13. ICD	Other Pertinent Diagnoses	Date
M25.461	Effusion right knee	06/28/26
I10.	Essential (primary) hypertension	06/28/26
M54.50	Low back pain unspecified	06/28/26
G89.29	Other chronic pain	06/28/26
D64.9	Anemia unspecified	06/28/26
G43.909	Migraine unsp not intractable without status migrainosus	06/28/26
F41.1	Generalized anxiety disorder	06/28/26
F32.9	Major depressive disorder single episode unspecified	06/28/26
K21.00	Gastro-esophageal reflux dis with esophagitis without bleed	06/28/26
Z91.81	History of falling	06/28/26
Z79.82	Long term (current) use of aspirin	06/28/26
Z85.3	Personal history of malignant neoplasm of breast	06/28/26

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

ACETAMINOPHEN 325 mg/tablet / Give 2 tablet by mouth every 6 hours as needed for MILD TO SEVERE PAIN NOT TO EXCEED 3GM ACETAMINOPHEN PER DAY
ANASTROZOLE 1 MG / 1 Tablet by mouth in the morning for Hx OF BREAST CANCER
Aspirin Ec - Aspirin Delayed Release 81 MG / 1 Tablet by mouth in the morning for DVT PROPHYALAXIS DO NOT CRUSH
Lexapro - Escitalopram Oxalate 20 MG / 1 Tablet by mouth at bedtime for DEPRESSION
Lyrica - Pregabalin 150 MG / 1 Capsule by mouth three times a day for Pain ADMINISTER WITH FOOD
OMEPRAZOLE Delayed Release 40 MG / 1 Tablet by mouth one time a day for GERD BEFORE BREAKFAST
Oscal With Vitamin D - Calcium Acetate 500-200 MG-UNIT / 1 Tablet by mouth two times a day for osteoporosis
PRAVASTATIN 40 MG / 1 Tablet by mouth at bedtime for HLD
Senokot S - Senna 8.6-50 MG / 1 Tablet by mouth every morning and at bedtime for CONSTIPATION
Topamax - Topiramate 50 MG / 1 Tablet by mouth every morning and at bedtime for MIGRAINES
Viton-C Tablet 65-125 MG (Iron-Vitamin C) Give 1 tablet by mouth in the morning for Anemia
Metoprolol Succinate - Metoprolol Succinate 12.5 MG / 1 Tablet by mouth in the morning for HTN HOLD MEDICATION IF PULSE < 60 AND/OR SYSTOLIC BLOOD PRESSURE < 100 mmHg
BARRIER CREAM Apply to BUTTOCKS AND PERI AREA topical every shift and every 1 hour as needed for SKIN PROTECTION AFT SOAP/H20

14. DME and Supplies:

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

15. Safety Measures:

standard precautions, hand rails, fall precautions, , , ambulates with device, walker precautions, smoke detectors , medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, hip precautions, bathroom safety, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, , Endurance

18.B. Activities Permitted

Up As Tolerated, Walker, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

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

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

Homebound status: Due to diagnosis of Nondisplaced 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.

Clinical Condition Requiring Homecare:

The patient is a 71-year-old female admitted to home health services following hospitalization and a subsequent subacute rehabilitation stay after sustaining a mechanical fall at home that resulted in a right intertrochanteric femur fracture. She denied loss of consciousness or head injury at the time of the fall. The patient underwent successful open reduction and internal fixation (ORIF) with intramedullary nail placement on June 1 without postoperative complications. She has since returned home and requires continued skilled home health services for comprehensive nursing assessment, medication management, postoperative monitoring, pain management, rehabilitation, and education to promote recovery and prevent rehospitalization. The patient's past medical history is significant for breast cancer, hypertension, gastroesophageal reflux disease (GERD), migraine headaches, anxiety, depression, muscle weakness, gait abnormalities, anemia, chronic low back pain, and prior spinal surgery. Prior to her injury, she was independent with all activities of daily living (ADLs), instrumental activities of daily living (IADLs), community ambulation without the use of an assistive device, and stair negotiation. She resides with her husband, who is available to assist with her care and actively participates in the rehabilitation process. Upon skilled nursing assessment, the patient was alert and oriented to person, place, time, and situation and able to communicate her needs appropriately. Vital signs were obtained and remained stable. She reported postoperative right hip pain that is adequately controlled with prescribed analgesics and rest. Assessment of the surgical incision to the right hip revealed a clean, dry, and intact wound with well-approximated edges. Mild postoperative swelling was present; however, there was no erythema, increased warmth, drainage, or other signs of infection. Respiratory assessment revealed clear bilateral lung sounds with even and unlabored respirations. Cardiac assessment demonstrated a regular heart rate and rhythm. Abdominal examination was soft and non-tender with active bowel sounds in all quadrants. The patient reported an adequate appetite and fluid intake and denied nausea, vomiting, or urinary difficulties. The patient ambulates short distances with a walker and requires assistance due to generalized weakness, impaired balance, decreased endurance, and postoperative pain. Gait is slow and antalgic, and she requires assistance with transfers, bed mobility, and certain activities of daily living. She remains at high risk for falls. Physical therapy evaluation demonstrated significant functional impairments, including impaired balance with a Tinetti Balance Assessment score of 12/28, right lower extremity weakness, decreased endurance, difficulty with transfers and bed mobility, and impaired gait mechanics. Despite these limitations, the patient demonstrates good motivation and excellent rehabilitation potential. Skilled physical therapy is indicated to address gait training, strengthening, balance,

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/28/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Nicole Herpick
2021B Emmorton Rd
Bel Air, MD 21015
PHONE: 4105691001 FAX: 14105691569 NPI: 1770132391

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 : 06/15/2026

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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endurance, transfer training, and fall prevention. The patient and her husband were instructed on safe assistance techniques for right lower extremity straight leg raises and supine heel slides to support her home exercise program. Medication reconciliation was completed without discrepancy. The patient and caregiver received education regarding the prescribed medication regimen, including pain medications, anticoagulant precautions if applicable, medication side effects, and the importance of adherence to prescribed therapy. Comprehensive patient and caregiver education was provided regarding fall prevention strategies, home safety modifications, consistent use of the walker, and adherence to orthopedic weight-bearing precautions. Instruction was reinforced regarding proper incision care and recognition of signs and symptoms of infection, including increased redness, warmth, drainage, fever, worsening pain, or swelling. Pain management strategies were reviewed, including both pharmacologic and non-pharmacologic interventions. Education was also provided on maintaining adequate nutrition, hydration, and increased protein intake to promote wound healing, as well as constipation prevention while taking opioid pain medications. The patient and caregiver were instructed to promptly notify the physician of fever, worsening pain, inability to bear weight, chest pain, shortness of breath, calf pain or swelling, wound complications, or any other concerning postoperative symptoms. Both the patient and caregiver verbalized understanding of all education provided. Occupational therapy completed an evaluation and determined that the patient is currently functioning independently with basic self-care activities, functional transfers, and functional mobility within the home following approximately three weeks of occupational therapy intervention. No additional skilled occupational therapy services are indicated at this time, and the patient will be discharged from OT following the evaluation. The plan of care includes continued skilled nursing visits for ongoing comprehensive assessments, medication management, postoperative pain management, incision monitoring, and reinforcement of disease process and postoperative education. Nursing will continue to monitor for signs of infection, impaired wound healing, deep vein thrombosis, and other postoperative complications while coordinating care with the patient's primary care provider and orthopedic surgeon. Skilled physical therapy will continue to provide gait training, therapeutic exercise, strengthening, balance activities, endurance training, transfer training, and fall prevention interventions to maximize mobility and safety. Home safety measures and fall precautions will remain in effect throughout the episode of care. The overall goals are to promote surgical healing, improve strength, balance, and functional mobility, maximize independence with daily activities, prevent complications and rehospitalization, and safely return the patient to her prior level of function.
 Date of Order 06/28/2026 Orders Physician Face-to-Face Date: 06/15/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat due to Nondisplaced intertrochanteric fracture of right 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 Herpick, Nicole

SN Careplans

SN WK1: 1 (06/28/26-07/04/26) ,WK2: 1 (07/05/26-07/11/26) ,WK3: 1 (07/12/26-07/18/26) ,WK4: 1 (07/19/26-07/25/26) ,WK5: 1 (07/26/26-08/01/26) ,WK6: 1 (08/02/26-08/08/26)

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: D0160 - Depression, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, muscle weakness, limited range of motion, swelling of affected area, limited strength, limited endurance, #1 - Observable Surgical Wound - Other - Right hip - , #2 - Observable Surgical Wound - Other - Right lateral lower thigh above the knee -

SN Goals

PATIENT-STATED GOAL: Patient states she wants to get back to being independent with her ADL's

GOALS
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
* 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

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/28/2026

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PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - Right hip -: No wound care OTA, physician-ordered wound care: #2 - Observable Surgical Wound - Other - Right lateral lower thigh above the knee -: No wound care OTA, cough/deep breathing exercises, incentive spirometer, teach/coordinate/arrange medication packaging and/or administration

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, * 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 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, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (06/28/26-07/04/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car 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, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Medication management : Reviewed meds with pt, home exercise program: AA, rle heelslides, SLR, seated laq, aps, hip abduction, add, standing hip flexion, hamstring curls, dynamic standing balance exercises: Work on wt shifting, reaching outside bos, gait training on uneven surfaces, 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

PT Goals

PATIENT-STATED GOAL: To be able to get off the walker and walk on my own and drive

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

OT Careplans

OT WK1: 1 (06/28/26-07/04/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, 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

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Evaluation only

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Shower/Bathe Self - 05. Setup or clean-up assistance

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

Sit to Stand - 06. Independent

Car 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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

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Picking Up Object - 04. Supervision or touching assistance

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

06/28/2026