Home Health Certification and Plan of Care

Order ID: 1150/20597

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
57355530	05/19/2026	From: 07/18/2026 To: 09/15/2026	25834	217058

6. Patient's Name and Address
Carmen Valentin Serrano
102 North Charter Rd Apt B,
Glen Burnie, MD 21061-
787-526-9203

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 11/03/1939 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S32.10XD	Unsp fracture of sacrum subs for fx w routn heal	05/19/26

13. ICD	Other Pertinent Diagnoses	Date
M53.2X1	Spinal instabilities occipito-atlanto-axial region	05/19/26
S81.812D	Laceration without foreign body left lower leg subs encntr	05/19/26
M48.02	Spinal stenosis cervical region	05/19/26
F03.90	Unsp dementia unsp severity without beh/psych/mood/anx	05/19/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	05/19/26
I48.91	Unspecified atrial fibrillation	05/19/26
E78.5	Hyperlipidemia unspecified	05/19/26
R26.89	Other abnormalities of gait and mobility	05/19/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	05/19/26
Z91.81	History of falling	05/19/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	05/19/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	05/19/26

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

CLOPIDOGREL 75 mg / 1 Tablet by mouth one time a day for TIA
Metoprolol Succinate - Metoprolol Succinate Extended Release 24 Hour 25 MG / 1 Tablet by mouth one time a day for HTN
METFORMIN 500 mg tablet by mouth two times a day for Diabetes mellitus
MEMANTINE HYDROCHLORIDE 10 mg / 1 Tablet by mouth two times a day for Dementia
DONEPEZIL HYDROCHLORIDE 5 mg / 1 Tablet by mouth at bedtime for Dementia
ATORVASTATIN 40 mg / 1 Tablet by mouth at bedtime for hyperlipidemia
ACETAMINOPHEN 325 mg/tablet / Give 2 tablet by mouth every 6 hours as needed for pain 1-5 do not exceed more than 3 gms daily

14. DME and Supplies:
wheelchair, commode, 4 wheeled walker

15. Safety Measures:
walker precautions, ambulates with assistance, standard precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET,

17. Allergies:
cipro cephalosporin nsaids

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
No Restrictions

19. Mental & Pyschosocial Status: COGNITION: 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer, ANXIETY: , SOCIAL ISOLATION: 0 Dependent, BEHAVIORAL ISSUES: 2 independent, HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: - , MOBILITY: -

22.B.Discharge Plans
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Unspecified fracture of sacrum, 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: The patient is an 87-year-old Spanish-speaking female with a past medical history significant for dementia, atrial fibrillation not currently on anticoagulation therapy, hyperlipidemia, type 2 diabetes mellitus, history of transient ischemic attack on Plavix, and prior hip replacement, who was recently hospitalized following a fall resulting in traumatic injury to the back and hips. Diagnostic imaging revealed minimally displaced left sacral fractures and central canal stenosis. The patient was evaluated at a second hospital for possible surgical intervention; however, surgery was ultimately not performed, reportedly due to the patient's advanced age and determination that surgical intervention was not indicated. Following hospitalization, the patient completed approximately four weeks of subacute rehabilitation at Autumn Lake before returning home via EMS transport. The patient currently resides in an apartment with her daughter, grandson, and niece, all of whom provide significant assistance with daily care and supervision. The patient and daughter primarily speak Spanish, while the niece, who speaks English, served as the primary spokesperson and interpreter during the assessment. Family members report fluctuating cognition, with the patient experiencing both good and bad days regarding memory, orientation, and ability to participate appropriately in conversation. The patient is currently bedbound and non-ambulatory secondary to severe lower extremity weakness, impaired balance, pain, and inability to tolerate standing for more than a few seconds without risk of falling. Since discharge home, the patient has required total assistance for transfers and mobility, with family currently transferring her from the sofa to a bedside commode only. Although a hospital bed is available in the home, the patient prefers sleeping on the sofa. Prior to the fall and hospitalization, the patient was ambulatory with a rollator walker independently within the apartment and was able to perform basic mobility tasks with significantly greater independence. At the time of nursing assessment, the patient was stable and in no acute distress. Vital signs were within normal limits. No open wounds or skin breakdown were noted. The patient denied pain while at rest during the visit; however, family reported that the patient experiences significant pain in the low back, hips, and bilateral knees when sitting upright or attempting to stand. Family also reported that the patient maintains a good appetite and is able to feed herself independently during meals. No falls have occurred since hospital discharge. No upcoming physician appointments were initially reported; however, the patient is scheduled for orthopedic follow-up with Dr. Lysa Charles on 05/28/2026 to clarify weight-bearing status and determine any mobility or activity restrictions related to the sacral fractures. Physical therapy evaluation identified significant deficits including low back, bilateral hip, and bilateral knee pain, decreased bilateral lower extremity strength, impaired balance, inability to ambulate safely, inability to tolerate prolonged standing, dependence with transfers, impaired functional mobility, decreased safety awareness, and very high fall risk. The patient currently requires extensive physical assistance for all mobility tasks and is unable to independently pivot or transfer safely. Homebound status is supported by advanced dementia, sacral fractures, severe weakness, inability to ambulate, and the need for wheelchair mobility and continuous caregiver assistance to safely leave the home. Occupational therapy evaluation further revealed that the patient is currently dependent for basic activities of daily living, including dressing, toileting, hygiene, and transfers. The patient is also dependent for all instrumental activities of daily living. Prior to the recent fall, the patient had utilized a rollator walker for approximately 8-9 years for indoor ambulation and maintained significantly greater independence. Skilled occupational therapy intervention is medically necessary to improve strength, increase activity tolerance and endurance, reduce caregiver burden, prevent falls, prevent further loss of function, and maximize participation in daily activities and quality of life. Skilled nursing education was provided to the patient and family regarding fall prevention, safe transfer techniques, pressure injury prevention, pain management, home safety, supervision needs, and monitoring for changes in condition requiring physician notification. Skilled physical therapy services are medically necessary to address strengthening, transfer training, balance retraining, functional mobility, caregiver education, and progression toward safe ambulation as medically appropriate. Continued skilled occupational therapy services are also warranted to address ADL retraining, positioning, endurance, safety awareness, and preservation of functional abilities. The patient remains at high risk for falls, further functional decline, immobility-related complications, and rehospitalization without continued skilled home health intervention.
 Date of Order 07/16/2026 Orders Physician Face-to-Face Date:

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/16/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Sharon Chung
7670 Quarterfield Rd
Glen Bernie, MD 21061
PHONE: 410-508-7650 FAX: 1-410-508-7701 NPI: 1295026045

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 : 05/12/2026

27. Attending Physician's Signature and Date Signed **07/22/2026**: 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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05/12/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Unspecified fracture of sacrum, 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
 4 - Recertification Notes: The patient is recertified due to high risk of falls/history of falls, sacral fracture, and dementia requiring human assistance and a w/c to safely leave the home. Continued skilled therapy remains medically necessary to address transfers, sit-stand, gait training on level surfaces with walker, caregiver training, and to maximize functional mobility and safety.
 Physician Chung, Sharon

SN Careplans

SN Goals

PT Careplans

PT WK2: 1 (07/19/26-07/25/26) ,WK3: 1 (07/26/26-08/01/26)

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, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet, GG0170M1 - 1 - Step (curb), GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface

PROCEDURES: wheelchair training, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., static standing balance exercises: Static standing with walker, dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., transfers training: teach caregivers how to safely assist with transfers, assist with mobility: teach caregivers how to safely assist with pt mobility, assist with home exercise program: teach caregivers how to safely assist with HEP

TEACH PATIENT/CAREGIVER: Car Transfer - 02. Substantial/maximal assistance, Chair to Bed to Chair - 02. Substantial/maximal assistance, Sit to Stand - 02. Substantial/maximal assistance, Toilet Transfer - 03. Partial/moderate assistance, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, Walk 10 Feet - 02. Substantial/maximal assistance

PT Goals

PATIENT-STATED GOAL: To be able to walk again safely inside of apt

GOALS
Sit to Stand - 02. Substantial/maximal assistance

Chair to Bed to Chair - 02. Substantial/maximal assistance

Car Transfer - 02. Substantial/maximal assistance

Toilet Transfer - 03. Partial/moderate assistance

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

Walk 10 Feet - 02. Substantial/maximal assistance

OT Careplans

OT WK2: 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:

HOSPITALIZATION RISKS: 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.

OT Goals

PATIENT-STATED GOAL: improve R ROM, walk to bathroom able to take bath by herself

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

Toileting Hygiene - 05. Setup or clean-up assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

Oral Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

07/16/2026

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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:Advanced Directive SEE MOLST

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing, abnormal blood pressure, M1033 - Exhaustion, abnormal BS < 70/140 > mg/dL, limited endurance, balance deficit, loss of appetite, bruising/discoloration, discolored patches of skin

PROCEDURES: Home exercise program : exe at home, Medication review: med list, Therapeutic activity : exe dring the visit, apply anti-embolitic stockings, apply compression bandage, physician-ordered wound care, glucose testing via monitor, equipment training, work simplification/energy conservation

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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, 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

Eating - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

07/16/2026