Home Health Certification and Plan of Care

Order ID: 1150/21007

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
100047391	06/05/2026	From: 08/04/2026 To: 10/02/2026	26458	217058

6. Patient's Name and Address
Kathryn Mokwa
8480 Ice Crystal Drive Unit N,
Laurel, MD 20723-
412-951-9905

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 05/06/1940 **9.Sex** 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

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

Xalatan - Latanoprost Ophthalmic Solution 0.005 % / 1 drop both eyes in the evening
Lipitor - Atorvastatin Calcium 20 mg tablet by mouth in the evening
Cardizem Cd - Diltiazem Hydrochloride 24 hr 180 mg capsule by mouth in the evening Admin Instructions: Do not chew, crush or open.
Colace - Docusate Sodium 100 mg capsule by mouth twice a day
Tambocor - Flecainide Acetate 100 mg tablet by mouth twice a day Admin Instructions: Absorption of flecainide is decreased when administered with milk-containing products. Please confirm optimal feeding regimen and timing of flecainide administration with authorized prescriber.
Synthroid - Levothyroxine Sodium 75 mcg tablet by mouth once a day Admin Instructions: Give on empty stomach. Turn off tube feeding 2 hours prior to administration and hold tube feeding for 2 hours after administration.
Cozaar - Losartan Potassium 100 mg tablet by mouth once a day Admin Instructions: Hold if SBP < 100
Protonix - Pantoprazole Sodium EC 40 mg tablet by mouth twice a day Admin Instructions: Do not crush or chew.
Tylenol - Acetaminophen 650 mg tablet by mouth as necessary Every 4 hours. PRN Reason: Mild pain (1-3). May also be administered per patient/Legally Authorized Health Care Decision-Maker (LAHD) preference for > 3 pain score., Temperature > 38 C (100.4 F), Headaches. Admin Instructions: ** CAUTION - Maximum acetaminophen dose not to exceed 4000 mg/24 hours from ALL sources **
Milk Of Magnesia - Simethicone 400 MG/5ML / Give 30 ml by mouth as necessary Daily. PRN Reason: Constipation
Famotidine - Famotidine 40 mg by mouth once a day At night 1 pill
Amilodipine - Amlodipine Besylate 5 mg by mouth once a day

14. DME and Supplies:
reacher, walker

15. Safety Measures:
standard precautions, ambulates with assistance, None of the above

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
lisinopril

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Transfer bed/Chair, Walker, Cane

19. Mental & Pyschosocial Status: COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: , SOCIAL ISOLATION: , BEHAVIORAL ISSUES: WFL, HISTORY OF DEPRESSION:

20. Prognosis: good

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 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: 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 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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/30/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Lauren Psoras
6740 Alexander Bell Dr Ste 300
Columbia, MD 21046
PHONE: 4105640000 FAX: 14105640032 NPI: 1003651761

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 : 05/27/2026

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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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 07/30/2026 Orders 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 hhadl'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
 4 - Recertification Notes: The patient is recertified due to persistent deficits in dynamic standing balance, coordination, stair negotiation, and overall functional mobility following hospitalization for left axillary hematoma with associated left shoulder pain and T7 compression fracture. The patient continues to require skilled home health physical therapy for progressive bilateral lower extremity therapeutic strengthening, transfer training, bed mobility, gait training with rolling walker, standing balance activities, stair training, postural control, lower extremity coordination, and skilled cueing for safe movement patterns and assistive device management to reduce fall risk and improve safety with household mobility.
 Physician Psoras, Lauren

SN Careplans

SN Goals

PT Careplans

PT WK1: 1 (08/04/26-08/08/26) ,WK2: 1 (08/09/26-08/15/26) ,WK3: 1 (08/16/26-08/22/26) ,WK4: 1 (08/23/26-08/29/26) ,WK5: 1 (08/30/26-08/31/26)

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: WFL

HOSPITALIZATION RISKS: 10. None of the above

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

PT Goals

PATIENT-STATED GOAL: To get my endurance back

GOALS
Chair to Bed to Chair - 06. Independent

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

Toilet Transfer - 06. Independent

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

Car Transfer - 06. Independent

4 Steps - 05. Setup or clean-up assistance

12 Steps - 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

Sit to Stand - 06. Independent

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/30/2026

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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: GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), 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, GG0170D1 - Sit to Stand, abnormal blood pressure, abnormal thyroid <> 0.40 - 4.50 mIU/mL, constipation, limited endurance, muscle weakness, balance deficit, loss of appetite, discolored patches of skin

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., cough/deep breathing exercises, incentive spirometer, physician-ordered wound care, wound vacuum, 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

OT Careplans

OT WK1: 1 (08/04/26-08/08/26) ,WK2: 1 (08/09/26-08/15/26) ,WK3: 1 (08/16/26-08/22/26) ,WK4: 1 (08/23/26-08/29/26) ,WK5: 1 (08/30/26-08/31/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, 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: Improve UE strength : L strength strength to 3+, Improve active L UE rom : improve active ROM to 45, cough/deep breathing exercises, incentive spirometer, home exercise program: exe for shoulder, elbow and wrist, 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, * 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Able to use l arm, get up and move more,

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

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

Shower/Bathe Self - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
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