Home Health Certification and Plan of Care

Order ID: 1150/21703

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3CJ2KD2PA86	08/29/2026	From: 08/29/2026 To: 10/27/2026	29612	217058

6. Patient's Name and Address

Donna Orange
6384 Morning Time Lane,
COLUMBIA, MD 21044-
443-812-2623

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 09/28/1945 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S82.392D	Oth fx lower end of l tibia subs for clos fx w routn heal	08/29/26

13. ICD	Other Pertinent Diagnoses	Date
S82.402D	Unsp fx shaft of left fibula subs for clos fx w routn heal	08/29/26
L89.153	Pressure ulcer of sacral region stage 3	08/29/26
L89.313	Pressure ulcer of right buttock stage 3	08/29/26
E44.0	Moderate protein-calorie malnutrition	08/29/26
C50.911	Malignant neoplasm of unsp site of right female breast	08/29/26
D63.0	Anemia in neoplastic disease	08/29/26
I10.	Essential (primary) hypertension	08/29/26
E11.9	Type 2 diabetes mellitus without complications	08/29/26
I48.91	Unspecified atrial fibrillation	08/29/26
I45.2	Bifascicular block	08/29/26
F33.9	Major depressive disorder recurrent unspecified	08/29/26
E78.5	Hyperlipidemia unspecified	08/29/26
M81.0	Age-related osteoporosis w/o current pathological fracture	08/29/26
Z86.711	Personal history of pulmonary embolism	08/29/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	08/29/26
Z79.01	Long term (current) use of anticoagulants	08/29/26
Z91.81	History of falling	08/29/26

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

Loperamide Hydrochloride - Loperamide Hydrochloride 2 mg 2mg; 1 cap by mouth as necessary with each loose stool for diarrhea
Pantoprazole Sodium - Pantoprazole Sodium Delayed Release 40 MG / 1 Tablet by mouth one time a day for GERD BEFORE BREAKFAST
Amlodipine Besylate - Amlodipine Besylate 5 MG / 1 Tablet by mouth in the morning for HTN HOLD FOR SBP < 110
ATORVASTATIN 80 MG / 1 Tablet by mouth at bedtime for HLD
Jardiance - Empagliflozin 10mg; 1 tab by mouth in the morning DM
Calcium 500 + D3 (Calcium Carbonate-Cholecalciferol) 5MCG (200 IU) by mouth in the morning and at bedtime for CALCIUM/VITAMIN D DEFICIENCY
Predisone - Prednisone 20MG; 1 TAB by mouth once a day EVERY EVENING
Metformin Hcl - Metformin Hydrochloride 500 MG / 1 Tablet by mouth at bedtime for DIABETES TAKE WITH FOOD TO AVOID GI UPSET
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5MG; 1 TAB by mouth every 6 hours AS NEEDED FOR PAIN
ELIQUIS 2.5 MG / 1 Tablet by mouth every morning and at bedtime for AFib
ACETAMINOPHEN 500 MG / 1 Tablet by mouth every 8 hours for PAIN NOT HOUSE STOCK IF ROUTINE ADMINISTRATION - NOT TO EXCEED 3GM ACETAMINOPHEN PER DAY.
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000 UNIT / 1 Tablet by mouth in the morning for VITAMIN D DEFICIENCY
Bupropion Hydrochloride - Bupropion Hydrochloride ER 24 Hour 150 MG / 1 Tablet by mouth in the morning for Depression
Empagliflozin 10 MG / 1 Tablet by mouth in the morning for Type 2 DM

14. DME and Supplies:

bath bench, wheelchair, walker, cane

15. Safety Measures:

wheelchair precautions, standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, ambulates with assistance, transfer with assist, supervision at all times, anticoagulant precautions, activity supervision

16. Nutrition:

low cholesterol, low sodium, diabetic

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted

Cane, Walker, Exercises Prescribed, Wheelchair, Up As Tolerated

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: 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: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Other fracture of lower end of left tibia, 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 was discharged home with skilled nursing (SN), physical therapy (PT), and occupational therapy (OT) services following hospitalization with diagnoses including chemotherapy treatment, diarrhea, generalized weakness, and protein-calorie malnutrition. Past medical history is significant for recurrent falls, displaced left distal tibial and proximal fibular fractures status post left tibial open reduction and internal fixation (ORIF) on 7/27/2026, type 2 diabetes mellitus, hypertension, hyperlipidemia, major depressive disorder, pulmonary embolism, bilateral breast cancer, and anemia. Skilled nursing services were ordered at a frequency of 1W1, 2W1, and 1W6, with PT and OT evaluations ordered to assess and address the patient's functional limitations. The patient's spouse and paid caregiver provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. Upon assessment, the patient was alert and oriented x3, although intermittently forgetful. She denied shortness of breath, and lung sounds were clear throughout. The patient reported a fair but improving appetite. A left subcutaneous dressing was noted in place over the implanted port site. The left ankle surgical incision was closed, with several Steri-Strips remaining in place. A previously documented stage 3 pressure ulcer to the right buttock was noted to be closed. The patient is incontinent and wears a diaper. She demonstrates significant functional impairment and requires maximum assistance for transfers and ambulation. A rolling walker is utilized to promote safe mobility. The patient's spouse and paid caregiver remain available to assist with her care and mobility needs. Skilled nursing reviewed the patient's medications with the patient and caregiver, including medication names, prescribed doses, frequency, indications, and pertinent potential side effects. It was noted that the patient is not currently monitoring blood glucose levels in the home despite her history of type 2 diabetes mellitus. The patient and caregiver were receptive to the education provided. Continued skilled nursing intervention is indicated for ongoing assessment of the patient's medical status, medication management and education, monitoring for complications related to her multiple comorbidities and recent chemotherapy, nutritional status, skin integrity, surgical site healing, diabetes management, and overall safety. PT and OT will address impaired strength, mobility, transfers, ADL performance, and functional independence. The plan of care will focus on preventing falls and further functional decline, promoting safe mobility with the rolling walker, supporting nutritional and medical stability, monitoring wound and skin status, and maximizing the patient's safety and independence in the home environment.
 Date of Order 08/29/2026 Orders Physician Face-to-Face Date: 08/20/2026 Clinical Condition Requiring Home Care per

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 08/29/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Rafeena Bacchus
5900 Waterloo Rd Ste 200
Columbia, MD 21044
PHONE: 4107402900 FAX: 14107402955 NPI: 1336374321

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 : 08/20/2026

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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Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Other fracture of lower end of left tibia, 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
 Physician Bacchus, Rafeena

SN Careplans

SN WK1: 1 (08/29/26-08/29/26) ,WK2: 1 (08/30/26-09/05/26) ,WK3: 2 (09/06/26-09/12/26) ,WK4: 1 (09/13/26-09/19/26) ,WK5: 1 (09/20/26-09/26/26) ,WK6: 1 (09/27/26-10/03/26) ,WK7: 1 (10/04/26-10/10/26) ,WK8: 1 (10/11/26-10/17/26)

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), 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:MOLST: 1a) ATTEMPT CPR

09/02/2026 Problems : #1 - Non-Observable Surgical Wound - Anterior Left Ankle -
#2 - 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles not exposed. - Other - sacrum - Pressure Injury/Ulcer - Wound Stage: 3 - Pressure Injury
M1033 - Exhaustion
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
dependent edema
weak hand grips
balance deficit
muscle weakness
limited range of motion
limited strength
limited endurance
meal preparation
D0160 - Depression

PROCEDURES: cough/deep breathing exercises

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,

SN Goals

PATIENT-STATED GOAL: I WANT TO FEEL BETTER AND WALK BY MYSELF

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
* 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
* 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

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/29/2026

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medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, 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, meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/29/2026