FAX COVER PAGE

HomeCentris HEALTHCARE
HOME-CENTRIC HEALTHCARE STRATEGIES

Date: 05/13/2026

To:
Diane Kepner , MD

From:
HomeCentris Healthcare LLC
10 Crossroads Drive, Suite 102
Owings Mills, MD 21117-8284

Phone: 410-321-8448

Fax: 410-559-3002

Subject:
Form Submission

Memo:

Please review the attached document.

URGENT: Please review and respond to this fax transmission promptly.

Home Health Certification and Plan of Care

Order ID: 1150/18521

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
4GG7RJ2JF78	05/07/2026	From: 05/07/2026 To: 07/05/2026	25487	217058

6. Patient's Name and Address

Sharon Fraass
9808 Fox HIll Rd,
PERRY HALL, MD 21128-
410-868-3883

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 12/30/1946 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
T81.41XA	Infct fol a proc superfic incisional surgical site init	05/07/26

13. ICD	Other Pertinent Diagnoses	Date
C51.9	Malignant neoplasm of vulva unspecified	05/07/26
E11.9	Type 2 diabetes mellitus without complications	05/07/26
I10.	Essential (primary) hypertension	05/07/26
E78.5	Hyperlipidemia unspecified	05/07/26
F41.9	Anxiety disorder unspecified	05/07/26
F32.A	Depression unspecified	05/07/26
R41.81	Age-related cognitive decline	05/07/26
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	05/07/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/07/26
M81.0	Age-related osteoporosis w/o current pathological fracture	05/07/26
G47.30	Sleep apnea unspecified	05/07/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	05/07/26
Z86.0100	Personal history of colonic polyps	05/07/26
Z86.711	Personal history of pulmonary embolism	05/07/26

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

ACETAMINOPHEN 1000 mg tablet by mouth every 8 hours as needed for pain
ACYCLOVIR 400 mg / 1 Tablet by mouth one time a day for wound infection
Atorvastatin Calcium - Atorvastatin Calcium 10 mg / 1 Tablet by mouth in the evening for HDL
Amlodipine Besylate - Amlodipine Besylate 5 mg / 1 Tablet by mouth once a day for hypertension
Cholecalciferol 50 mcg by mouth once a day for Supplement
Escitalopram Oxalate - Escitalopram Oxalate 20 mg / 1 Tablet by mouth one time a day for Depression
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) mg / 1 Tablet by mouth one time a day for iron deficiency
Hydrochlorothiazide - Hydrochlorothiazide 25 mg / 1 Tablet by mouth once a day for HTN
IBUPROFEN 600 mg / 1 Tablet by mouth every 6 hours as needed for pain
LOSARTAN POTASSIUM 100 mg / 1 Tablet by mouth one time a day for hypertension
MINOXIDIL 2.5 mg / 1 Tablet by mouth one time a day for hair loss
Ondansetron Hydrochloride - Ondansetron Hydrochloride 4 mg / 1 Tablet by mouth every 4 hours as needed for Nausea and Vomiting
Sennosides - Senna 8.6 mg tablet by mouth two times a day for Bowel Regimen
Polyethylene Glycol 3350 - Polyethylene Glycol 3350 Powder / Give 17 gram by mouth as necessary every 48 hours as needed for Constipation.
Tuberculin PPD Intradermal solution Inject 0.1 ml intradermally in the morning for R/O TB until 05/07/2026 23:59
Mounjaro Subcutaneous Solution Auto-Injector 2.5 MG/0.5ML / Inject 2.5 mg Subcutaneously one time a day every Sun for DM

14. DME and Supplies:

wound care supplies

15. Safety Measures:

medication safety, ambulates with assistance, standard precautions, fall precautions, diabetic precautions, activity supervision

16. Nutrition:

diabetic

17. Allergies:

aspartame cephalexin

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Up As Tolerated

19. Mental & Psychosocial 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: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, 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

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Infection following a procedure, superficial incisional surgical site, initial encounter, 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 78-year-old female admitted to home health services following a recent vulvectomy and subsequent flap surgery related to vulvar cancer diagnosed in February 2026. Her past medical history is significant for hyperlipidemia, Type 2 diabetes mellitus managed with weekly Mounjaro injections, anxiety, and depression. The patient underwent vulvectomy last month at Johns Hopkins Hospital. Although her immediate postoperative recovery was initially uncomplicated and she was discharged home, she later developed a postoperative wound infection identified during a follow-up surgical visit, requiring readmission to acute care hospitalization for further management. During hospitalization, the patient received intravenous antibiotics and was subsequently transitioned to oral antibiotic therapy. Her hospital course was further complicated by episodes of delirium, confusion, and impaired decision-making capacity; however, both the patient and family report that her mental status has significantly improved since discharge. The patient is now receiving home health skilled nursing services for ongoing comprehensive assessment and management, including cardiopulmonary monitoring, medication management, wound assessment and treatment, infection prevention education, safety monitoring, and disease process education. Skilled wound care was performed during the visit in accordance with physician orders for management of the postoperative vulvar surgical wound and flap site. The patient tolerated wound care procedures well without signs of distress or complications. No acute respiratory distress or cardiopulmonary abnormalities were noted during the visit. Ongoing monitoring of wound healing and infection status remains necessary due to the patient's recent postoperative infection history, advanced age, diabetes, and overall weakened condition. Extensive education was provided to the patient and caregiver regarding signs and symptoms of infection, proper wound care techniques, medication adherence, diabetic management, fall prevention strategies, pressure injury prevention, and indications for notifying the physician or seeking emergency medical attention. Reinforcement was also provided regarding maintaining adequate nutrition, hydration, and glycemic control to promote optimal wound healing. The patient remains homebound secondary to decreased strength, impaired mobility, limited endurance, postoperative weakness, and the need for assistance to safely leave the home environment. Continued skilled nursing services are medically necessary to monitor wound healing progression, prevent complications and rehospitalization, provide ongoing medication and disease management education, and ensure patient safety during postoperative recovery. The patient and caregiver verbalized understanding of all teaching provided and are in agreement with the established plan of care.
 Date of Order <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/07/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Diane Kepner
4801 Dorsey Hall Dr #201
Ellicott City, MD 21042
PHONE: 410-997-7660 FAX: 14109977660 NPI: 1487626461

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 : 04/28/2026

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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14px;">05/07/2026 Orders Physician Face-to-Face Date: 04/28/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Infection following a procedure, superficial incisional surgical site, initial encounter 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 Kepner, Diane

SN Careplans

SN WK1: 1 (05/07/26-05/09/26) ,WK2: 1 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26) ,WK4: 1 (05/24/26-05/30/26) ,WK5: 1 (05/31/26-06/06/26) ,WK6: 1 (06/07/26-06/13/26) ,WK7: 1 (06/14/26-06/20/26)

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, blood sugar < 60 > 300

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 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, M1745 - Behavioral Issues, M2020 - Oral Med Management, Financial, M2102f - Patient Supervision, meal preparation, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, discolored patches of skin, itchy skin, #1 - Observable Surgical Wound - Other - Left groin -

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - Left groin -: Cleanse left groin surgical wound with Vashe wound solution. Gently pack wound with Vashe-soaked gauze to base of wound/tunneling as indicated. Cover and secure with dry sterile dressing. Change dressing BID (twice daily) and PRN for saturation, soiling, or dislodgement. Monitor wound for signs/symptoms of infection including increased redness, warmth, swelling, drainage, foul odor, fever, or increased pain and notify MD as indicated. Document wound appearance, drainage, measurements, patient tolerance, and wound care performed each visit., cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, 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, * 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 be able to heal so I can go back to my home in Ellicott City MD

GOALS
patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

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
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/07/2026

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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, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/07/2026