FAX COVER PAGE

HomeCentris HEALTHCARE
HOME-CENTRIC HEALTHCARE STRATEGIES

Date: 09/01/2026

To:
Yisroel Schonfeld , PA

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: 1150/21627

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2EG5UX1FX82	08/26/2026	From: 08/26/2026 To: 10/24/2026	29198	217058

6. Patient's Name and Address

McLeod Townes
2216 Ken Oak rd,
BALTIMORE, MD 21209-
443-707-7133

7. Provider's Name, Address and Telephone Number

HomeCentris Healthcare LLC
10 Crossroads Drive, Suite 102
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410-321-8448
1487113239

8. DOB 05/06/1951 | **9.Sex** Male

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

Ammonium Lactate - Ammonium Lactate External Cream 12 % / Apply to Both legs/feet topical once a day for Dry Skin

11. ICD	Principal Diagnosis	Date
S06.5X1D	Traum subdr hem w LOC of 30 minutes or less subs	08/26/26

13. ICD	Other Pertinent Diagnoses	Date
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	08/26/26
N18.9	Chronic kidney disease u	08/26/26
D63.1	Anemia in chronic kidney disease	08/26/26
N39.0	Urinary tract infection site not specified	08/26/26
E55.9	Vitamin D deficiency unspecified	08/26/26
Z87.891	Personal history of nicotine dependence	08/26/26
Z86.711	Personal history of pulmonary embolism	08/26/26
Z91.81	History of falling	08/26/26

14. DME and Supplies:

cane

15. Safety Measures:

smoke detectors , emergency phone # clearly displayed, cardiac precautions, transfer with assist, supervision at all times, standard precautions, medication safety, diabetic precautions, fall precautions, bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted

Up As Tolerated, Cane

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: No

20. Prognosis: good

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

patient will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Traumatic subdural hemorrhage with a loss of consciousness of 30 minutes or less, 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 75-year-old male admitted to home health services following a recent discharge from a rehabilitation facility, where he spent several months recovering after a fall resulting in a traumatic subdural hematoma (SDH) with loss of consciousness. His significant past medical history includes diet-controlled type 2 diabetes mellitus with chronic kidney disease, history of urinary tract infection, traumatic subdural hematoma, vitamin D deficiency, history of pulmonary embolism, recurrent falls, nicotine use history, anemia, and prior amputation of three toes on the left foot. The patient is currently staying with his sister, Denise, who serves as his primary caregiver, in a basement apartment. The patient is considered homebound due to his history of falls, need for supervision for safety, impaired functional mobility, and the considerable and taxing effort required to leave the home. His goal for home health is to improve his physical function and mobility and to walk more normally. Start-of-care consent was reviewed and signed by the patient with understanding, and the patient and caregiver agreed with the plan of care. At the start-of-care assessment, the patient denied pain and reported no recent falls or urinary discomfort. His last bowel movement was yesterday. He experiences occasional urinary incontinence and wears pull-ups for management. Vital signs were stable, and no abnormal lung sounds were noted. No open wounds were identified. The skin of the lower extremities was noted to be dry, with dependent edema present. The left foot has a history of amputation of three toes. The patient was instructed to elevate his legs while sitting to assist with edema management and to apply lotion as prescribed to dry and cracked skin. The caregiver was educated regarding the potential use of support stockings for edema reduction, as appropriate. The patient also has anemia and was educated regarding dietary sources of iron. He reports allergies and uses Flonase for symptom relief. Medication review was completed, and high-risk medications were identified. The nurse contacted the pharmacy after learning that prescriptions had reportedly been called in but that a faxed prescription had not been received by Walgreens at Quarry Lake. The medications requiring pickup were reported to be over-the-counter medications, and the patient's sister planned to obtain them. The patient has a scheduled PCP appointment the following day and was instructed to bring his written medication information to the appointment for provider review and reconciliation. The patient and caregiver verbalized agreement with this plan. Physical therapy evaluation was completed. The patient demonstrates mild functional mobility deficits following his prolonged rehabilitation stay, including decreased strength, impaired posture, and reduced functional endurance. He ambulates approximately 40 feet twice on indoor level surfaces without an assistive device and with supervision, demonstrating increased trunk flexion. Outdoors, he is able to ambulate approximately one block over uneven concrete without an assistive device with close supervision and continued trunk flexion. He negotiates seven steps using a railing with supervision to exit the residence. Bed mobility is independent, while transfers to the bed, chair, and toilet require supervision for safety. Car-transfer ability was not assessed. The patient tolerated 10 repetitions of a comprehensive therapeutic exercise program including supine hip flexion, bridging, straight-leg raises, hip abduction, standing knee flexion, standing hip abduction, standing hip extension, plantarflexion, squats, seated knee extension, and ankle pumps. His Tinetti score is 23/28, reflecting an increased fall risk in the context of his recent fall history, SDH, impaired posture, and need for supervision. Skilled home PT is indicated to improve strength, postural control, balance, endurance, and functional mobility, with emphasis on safe gait, transfers, stair negotiation, fall prevention, and progression toward greater independence. Occupational therapy evaluation was also completed. The patient presents with mildly decreased independence with basic activities of daily living and requires supervision for transfers to ensure safety. He is able to perform shower transfers with modified independence using available grab rails. Significant bilateral upper-extremity range-of-motion and strength deficits were identified, which contribute to limitations with functional tasks and instrumental activities of daily living. The patient also reports poor appetite and becoming fatigued easily, indicating decreased overall endurance and activity tolerance. Skilled OT services are recommended to improve bilateral upper-extremity strength and range of motion, endurance, standing tolerance, ADL performance, transfer safety, and ability to safely participate in IADLs. The patient would benefit from continued interdisciplinary home health services focused on strengthening, functional mobility, fall prevention, safety awareness, energy conservation, and maximizing independence in the home environment. Skilled nursing is ordered at a frequency of one visit every other week for six weeks, with PT and OT services included in

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 08/26/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Yisroel Schonfeld
301 St Paul Pl
Baltimore, MD 21202
PHONE: 4103327460 FAX: 14103329669 NPI: 1033634431

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 : 08/03/2026

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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the plan of care.
 Date of Order 08/26/2026 Orders Physician Face-to-Face Date: 08/03/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Traumatic subdural hemorrhage with a loss of consciousness of 30 minutes or less 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 PT Eval Notes: OT Eval Notes:
 Physician Schonfeld, Yisroel

SN Careplans

SN WK1: 1 (08/26/26-08/29/26) ,WK3: 1 (09/06/26-09/12/26) ,WK5: 1 (09/20/26-09/26/26) ,WK7: 1 (10/04/26-10/10/26) ,WK9: 1 (10/18/26-10/24/26)

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), 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 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

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; 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 ; 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.

No open wounds noted
Advance Directive:SEE MOLST

08/27/2026 Problems : loss of appetite (NU)
M1400 - Dyspnea
M2020 - Oral Med Management
swelling in the arms/legs
dependent edema
dizziness/syncope
lightheadedness
balance deficit
muscle weakness
limited endurance
limited strength
limited range of motion
swelling of affected area
rough/scaly/cracked skin
swell/redness surround. skin
abnormal BS < 70/140 > mg/dL
meal preparation
M2102c - Med Admin
M2102f - Patient Supervision

SN Goals

PATIENT-STATED GOAL: To get to to my physical, not walk like a 75-year-old

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
* 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 increase caloric intake
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient is adequately supervised

patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/26/2026

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M2102d - Caregiver Performs Treatment
M1745 - Behavioral Issues
M1600 - UTI
M1610 - Urinary Incontinence
M1033 - Unintentional Weight Loss

PROCEDURES: cough/deep breathing exercises, apply anti-embolitic stockings, glucose testing via monitor: Diet controlled, monitor intake & output, bladder training, 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, * 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, * strategies to increase caloric intake, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (08/26/26-08/29/26) ,WK2: 1 (08/30/26-09/05/26) ,WK3: 1 (09/06/26-09/12/26) ,WK4: 1 (09/13/26-09/19/26)

08/28/2026 Problems : 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: Dynamic and static standing activities : Side stepping, tandem gait, tandem stance, unilateral stance, home exercise program: Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 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 stand straighter and get around by myself

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 (08/26/26-08/29/26) ,WK2: 1 (08/30/26-09/05/26) ,WK3: 1 (09/06/26-09/12/26) ,WK4: 1 (09/13/26-09/19/26)

08/27/2026 Problems : 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: ADL training: ADL training, Increase endurance to F+: Endurance activities, home exercise program: theraband ex's to increase strengh, and ROM ex's, equipment training, work simplification/energy conservation, transfers training

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven

OT Goals

PATIENT-STATED GOAL: be independent and feel good

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Signature of Physician:

Date

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

Date
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Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, 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, Increase endurance to F+

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Increase endurance to F+

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

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