HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022099

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
89174844	09/15/2026	09/15/2026 - 11/13/2026	30273	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Joan Palm 4011 ELAND ROAD PHOENIX, MD 21131	Female	08/11/1947	410-510-7442
	Email JLAINGE@COMCAST.NET		**Primary Language** English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI 1487113239		**Fax Number** 410-559-3002

Clinical Condition Requiring Homecare:

The patient is a 79-year-old female with a past medical history significant for atrial fibrillation, primary hypertension, hyperthyroidism, cardiomyopathy, and hyperlipidemia. The patient presented to the ER with worsening left foot pain, swelling, erythema, and blistering following a recent left foot injury. Approximately 10-14 days prior to admission, pruning shears fell onto the patient's left foot while she was wearing garden shoes. No skin break was initially noted; however, she subsequently developed significant bruising followed by marked swelling and pain. Pain was reported to worsen with standing and improve when lying flat. An urgent care X-ray showed an avulsion or nondisplaced fracture, and the patient was initially placed in a temporary splint. The podiatrist subsequently changed the splint to a boot, which caused rubbing and skin breakdown, and the patient was later transitioned to a post-op shoe. Two days later, she returned to urgent care due to worsening redness, swelling, and blistering concerning for infection and was started on cephalexin. After three days of antibiotic therapy with minimal improvement, the patient continued to experience pain with standing and progressive swelling and redness. By 9/7, she was transferred for worsening cellulitis with concern for hematoma or abscess, and CT reportedly suggested a possible infected hematoma. The patient subsequently underwent surgical incision and drainage of the lower extremity. The patient is currently non-weight-bearing to the left lower leg and ambulates using a leg scooter. The surgical wound care orders are to cleanse the surgical site with normal saline, apply Xeroform, cover with gauze and an ABD pad, and secure with Kerlix and an ACE bandage. The patient is currently taking Augmentin 875-125 mg, one tablet by mouth twice daily for 7 days. Skilled nursing completed medication review and provided wound care teaching, including the prescribed wound care regimen and monitoring of the surgical site for changes or signs of infection. The patient is a retired nurse and was receptive to the education provided. The patient previously resided with

Physician Statement on Homebound Status:

Due to diagnosis of Cellulitis of left lower limb, 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.

her husband in a single-level home and was independent with basic self-care, functional transfers, and functional ambulation. Following hospitalization and surgery, the patient presents with decreased standing balance, standing tolerance, bilateral upper-extremity strength, and overall activity tolerance, resulting in decreased independence with self-care, functional transfers, and functional ambulation. Her current non-weight-bearing status to the left lower leg further limits safe mobility and functional performance. Skilled occupational therapy services are recommended to address these deficits, promote safe and independent performance of ADLs and functional transfers, improve upper-extremity strength and activity tolerance, reinforce safety and compensatory techniques related to non-weight-bearing precautions, and facilitate the patient's return to her prior level of functional independence.

Date of Order
09/15/2026
Orders
Physician Face-to-Face Date: 09/12/2026
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Cellulitis of left lower limb
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
OT Eval Notes:

Physician
Watts, Charlotte

ICD-10 CM Principal Diagnosis: L03.116. Cellulitis of left lower limb

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
S92.812D	Other fracture of left foot 7thD	Yuvafem 10 MCG Tablet / Place 1 tablet vaginally vaginal two times per week Generic drug: estradiol. Vitamin D - Ergocalciferol 125 MCG (5000 UT) Capsule by mouth every evening RIVAROXABAN Take 20 MG Tablet by mouth once a day after dinner. Commonly known as: XARELTO TRAZODONE Take 50 MG Tablet by mouth nightly as needed PRAVASTATIN Take 20 MG Tablet by mouth at hour of sleep Commonly known as: PRAVACHOL Metoprolol Succinate - Metoprolol Succinate 25 MG 1/2 tablet extended release 24 HR / Take 12.5 mg by mouth daily Commonly known as: TOPROL XL MELATONIN 0 Take 5 MG Capsule by mouth nightly. SL MAGNESIUM 250 MG Tablet / Take 500 mg by mouth at hour of sleep. (2 tablets) LEVOTHYROXINE 125 MCG Tablet / Take 112 mcg by mouth daily before breakfast Commonly known as: SYNTHROID FUROSEMIDE Take 20 MG Tablet by mouth daily Commonly known as: LASIX FLUTICASONE 50 MCG/ACT nasal spray / 2 sprays by Each Nare Nasal as necessary daily for seasonal allergies. Commonly known as: FLONASE Docusate Sodium - Docusate Sodium Take 100 MG capsule by mouth 2 times daily Commonly known as: COLACE CALCIUM CARBONATE Take 1,000 MG by mouth in the evening AMIODARONE 200 MG / 1 Tablet by mouth daily Commonly known as: CORDARONE
I48.91	Unspecified atrial fibrillation	
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	
I50.32	Chronic diastolic (congestive) heart failure	
N18.31	Chronic kidney disease stage 3a	
E89.0	Postprocedural hypothyroidism	
E78.5	Hyperlipidemia unspecified	
I70.0	Atherosclerosis of aorta	
I42.9	Cardiomyopathy unspecified	
J44.9	Chronic obstructive pulmonary disease unspecified	
F41.9	Anxiety disorder unspecified	
F32.A	Depression unspecified	
M16.11	Unilateral primary osteoarthritis right hip	
K59.00	Constipation unspecified	
Z79.01	Long term (current) use of anticoagulants	
Z85.3	Personal history of malignant neoplasm of breast	
Z85.89	Personal history of malignant neoplasm of organs and systems	

Prognosis fair	**Mental and 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: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes
Functional Limitations Ambulation	**Activities Permitted** Other
DME & Supplies wound care supplies	**Safety Measures** activity supervision, bathroom safety, non-weight bearing LLE, standard precautions, ambulates with device, fall precautions, medication safety
Nutrition cardiac diet	**Allergies** chlorhexidine gluconate docetaxel sulfa antibiotics

Advance Directives
Durable power of attorney for health care/Medical power of attorney

Caregiver Status
1. Non-agency caregiver(s) currently provide assistance; 1. Non-agency caregiver(s) currently provide assistance

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.

DISCHARGE PLAN:
SN: patient will be responsible for managing treatment
OT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

OT Eval

SN CAREPLAN

SN frequency WK1: 2 (09/15/26-09/19/26),WK2: 2 (09/20/26-09/26/26),WK3: 2 (09/27/26-10/03/26),WK4: 2 (10/04/26-10/10/26),WK5: 2 (10/11/26-10/17/26),WK6: 2 (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: 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

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:Durable power of attorney for health care/Medical power of attorney

09/21/2026 Problems : #1 - Observable Surgical Wound - Anterior Right Foot -
M1400 - Dyspnea
M2020 - Oral Med Management
abnormal blood pressure
balance deficit
limited strength
swell/redness surround. skin

SN NARRATIVE

The patient is a 79 year old female with a past medical history of atrial fibrillation, primary hypertension, hyperthyroidism, cardiomyopathy, hyperlipidemia, etc. she reported that she went to the ER due to worsening left foot pain, swelling, and erythema after a recent foot injury. About 10-14 days before admission, pruning shears fell onto her left foot while she was wearing garden shoes and she had no skin break, but she developed significant bruising followed by marked swelling and pain. Pain is worse with standing and improves when lying flat, urgent care x-ray showed an avulsion or nondisplaced fracture and she was placed in a temporary splint. The Podiatrist changed it to a boot, which caused rubbing and skin breakdown, and she was later switched to a post-op shoe. Two days after, she returned to urgent care for worsening redness, swelling, and blistering concerning for infection and was started on cephalexin, but after 3 days had minimal improvement. By 9/7, she had persistent pain with standing and progressive swelling and redness, prompting transfer for worsening cellulitis with concern for hematoma or abscess; CT reportedly suggested a possible infected hematoma. A surgical incision and drainage of the lower extremity was done. Wound order for the surgical site is to Cleanse the surgical site with normal saline, apply xeroform, gauze ABD pad, secure with a kerlix and an ace bandage. She is on PO ABT Augmentin 875-125 MG / 1 Tablet by mouth twice a day for 7 days. She is non weight bearing to the left lower leg. Wound care teaching was provided to the patient, who is a retired nurse. Medication review was completed. The patient ambulates with a leg scooter.

SN GOALS

PATIENT-STATED GOAL: For wound to heal without infection.

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
* 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 self-administers medications as prescribed
* 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

D0160 - Depression

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Right Foot -: Cleanse the left foot surgical site with normal saline, apply xeroform, gauze ABD pad, secure with a kerlix and an ace bandage. Change 3X a week., cough/deep breathing exercises, incentive spirometer

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule

OT CAREPLAN

OT frequency WK1: 1 (09/15/26-09/19/26),WK3: 1 (09/27/26-10/03/26),WK5: 1 (10/11/26-10/17/26),WK7: 1 (10/25/26-10/31/26),WK9: 1 (11/08/26-11/13/26)

09/17/2026 Problems : GG0170N1 - 4 Steps
GG0130F1 - Upper Body Dressing
GG0130A1 - Eating
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene
GG0170E1 - Chair to Bed to Chair
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170P1 - Picking Up Object
GG0170O1 - 12 Steps
Pain Effect on Sleep
GG0170M1 - 1 - Step (curb)
GG0170K1 - Walk 150 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170I1 - Walk 10 Feet
GG0170G1 - Car Transfer
GG0170F1 - Toilet Transfer
GG0170D1 - Sit to Stand
M1400 - Dyspnea
Pain Interference with ADLs
Pain Interference with Therapy activities

PROCEDURES: Medication Review : Medication reviewed with patient with all medications in the home, home exercise program: Bilateral UE triceps extensions, biceps curls, armchair press-ups 2-3 sets 8-12 reps, equipment training, work simplification/energy conservation, gait training/stair training, 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, * 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT NARRATIVE

79 year old female presenting to skilled OT services s/p hospitalization secondary to worsening left foot pain, swelling, and erythema after a recent foot injury. Past medical history significant for atrial fibrillation, primary hypertension, hyperthyroidism, cardiomyopathy, hyperlipidemia.

Patient previously resided with her husband in a single level home. Patient previously independent with basic self care, functional transfer and functional ambulation independence. Patient currently presents with decreased standing balance, standing tolerance, bilateral UE strength and activity tolerance resulting in decreased self care, functional transfer, and functional ambulation independence. Skilled OT services recommended at this time to address deficits hindering Patient from returning to prior level of functional independence.

She is currently non weight bearing to the left lower leg.

OT GOALS

PATIENT-STATED GOAL: I want to return to gardening

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Shower/Bathe Self - 05. Setup or clean-up assistance

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

	Don/Doff Footwear - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent

Palm, Joan | Cert Period 09/15/26 - 11/13/26

	PT GOALS

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/15/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services. F2F date: 09/12/2026	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.
Certifying Physician or Allowed Practitioner Name and Address **Charlotte Watts** 2391 Greenspring Dr Timonium, MD 21093 NPI 1336481951	**Phone Number** 4103395500 **Fax Number** 14103395960

Physician's Signature and Date Signed

X

Charlotte Watts, MD
09/12/2026: Date of physician last face-to-face