HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115021703

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
3CJ2KD2PA86	08/29/2026	08/29/2026 - 10/27/2026	29612	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Donna Orange 6384 Morning Time Lane COLUMBIA, MD 21044	Female	09/28/1945	443-812-2623
	Email		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 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

Physician Statement on 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.

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 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

ICD-10 CM Principal Diagnosis: S82.392D. Oth fx lower end of l tibia subs for clos fx w routn heal

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
S82.402D	Unsp fx shaft of left fibula subs for clos fx w routn heal	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
L89.153	Pressure ulcer of sacral region stage 3	
L89.313	Pressure ulcer of right buttock stage 3	
E44.0	Moderate protein-calorie malnutrition	
C50.911	Malignant neoplasm of unsp site of right female breast	
D63.0	Anemia in neoplastic disease	
I10.	Essential (primary) hypertension	
E11.9	Type 2 diabetes mellitus without complications	
I48.91	Unspecified atrial fibrillation	
I45.2	Bifascicular block	
F33.9	Major depressive disorder recurrent unspecified	
E78.5	Hyperlipidemia unspecified	
M81.0	Age-related osteoporosis w/o current pathological fracture	
Z86.711	Personal history of pulmonary embolism	
Z79.84	Long term (current) use of oral hypoglycemic drugs	
Z79.01	Long term (current) use of anticoagulants	

Z91.81	History of falling	Empagliflozin 10 MG / 1 Tablet by mouth in the morning for Type 2 DM

Prognosis fair	**Mental and Psychosocial 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
Functional Limitations Ambulation, Endurance, Bowel/Bladder Incontinence	**Activities Permitted** Cane, Walker, Exercises Prescribed, Wheelchair, Up As Tolerated
DME & Supplies bath bench, wheelchair, walker, cane	**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
Nutrition low cholesterol, low sodium, diabetic	**Allergies** no known allergies

Advance Directives
MOLST: 1a) ATTEMPT CPR

Caregiver Status
2. Non-agency caregiver(s) need training/supportive services to provide assistance; 2. Non-agency caregiver(s) need training/supportive services to provide assistance

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.

DISCHARGE PLAN:
family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

3 - ROC - SN

OT Eval

PT Eval

SN CAREPLAN

SN frequency 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 -

SN NARRATIVE

The patient is a 80 year old female with a PMHx of chronic anemia, leukocytosis, breast cancer of both left and right breast, status post chemotherapy, history of immunotherapy, etc. She was hospitalized for diarrhea, underwent infectious work up which was negative, seen by gastroenterology and underwent colonoscopy, which showed diffuse inflammation. She was given IV Solumedrol 60mg, and then discharged with prednisone to follow up with oncology. She is home now with a private caregiver available all day and she lives with her husband. She is AXOX4, reports feeling less weak with reduced frequency of the diarrhea and the stool is semi formed. She has a lab order for a QuantiFERON TB test which will be drawn by the nurse on the next visit. Her vital signs were WNL. Respiration is even and unlabored. Medication review was completed with the patient and her husband and teaching on the need to create a calendar for the prednisone to keep accurate account of dosage administration and also to monitor her blood glucose levels, and document it. Patient has a PCP appointment on 9/9/26. The right hand is a restricted extremity with no procedures allowed on it. The patient has observable surgical sites on the left leg with steri strips on them. Will continue to follow the plan of care.

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

#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, 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	
	OT NARRATIVE Pt is a 80 yo female, was undergoing chemotherapy for breast CA. Pt was at rehab and fell and broken her L leg. Pt was operated and sent to rehab. patient admitted for diarrhea. underwent infectious work up which was negative. seen by GI and underwent olonoscopy which showed diffuse inflammation. She was given iv solumedrol 60mg and then discharged with prednisone to follow up with oncology. Pt complains of blurry vision, tremors in both hands more in left hand. Pt had Lymphedema in left ue, uses a sleeve to help with edema. Pt has generalized weakness, difficulty with transfers, mod to max assistance for dressing and bathing, dependent for toileting, uses commode for urination. OT skilled intervention is required for improving UE strength, gaining independence in ADLs.

	PT NARRATIVE Pt is an 80-year-old female with PMHx significant for bilateral breast cancer s/p mastectomy/chemotherapy, recently completing 12 sessions of chemotherapy, complicated by immune checkpoint inhibitor-associated colitis, chronic anemia, severe hypokalemia, and recent hospitalization with generalized deconditioning. Referred for skilled HHPT due to significant weakness and functional decline. Client presents with generalized/BLE weakness (grossly 3+/5), poor dynamic standing balance, decreased endurance, and wobbly/guarded gait requiring AD and assistance. Deficits limit safe bed mobility, transfers, and household ambulation. Education provided regarding post-op/wound monitoring, medication management, infection signs, fall prevention, and when to notify MD. Client is homebound due to weakness, impaired balance, limited endurance, need for assistance/AD, and taxing effort required to leave home. Skilled HHPT indicated to improve strength, balance, gait, transfers, endurance, and safe functional independence. **PT GOALS**

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 08/29/2026

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: 08/20/2026	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 **Rafeena Bacchus** 5900 Waterloo Rd Ste 200 Columbia, MD 21044 NPI 1336374321	**Phone Number** 4107402900 **Fax Number** 14107402955

Physician's Signature and Date Signed

X

Rafeena Bacchus
08/20/2026: Date of physician last face-to-face