# HOME HEALTH CERTIFICATION AND PLAN OF CARE

**Order ID 1150/22837**

## Patient Details

| Patient's HI Claim No. | Start of Care Date | Certification Period | Medical Record No. | Provider No. |
|---|---|---|---|---|
| 2EG5UX1FX82 | 08/26/2026 | 10/25/2026 - 12/23/2026 | 29198 | 217058 |

| Patient's Name and Address | Gender | Date of Birth | Phone Number |
|---|---|---|---|
| **McLeod Townes**<br>2216 Ken Oak rd<br>BALTIMORE, MD 21209 | Male | 05/06/1951 | 443-707-7133 |
| | Email | | Primary Language: English |

## Clinical Profile

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

**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

**Physician Statement on 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.

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 the plan of care.

Date of Order
10/21/2026
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

4 - Recertification Notes: The patient is recertified due to wound to left foot/amputated big toe requiring left foot wound care and prescribed Bactrim DS for skin infection every 12 hours daily for x7 days. The patient has dependent edema to bilateral lower extremities, abnormal kidney results with referral to nephrology, and requires continued skilled nursing for wound care, antibiotic education, compression wear, and monitoring, with SN frequency 1w6.

Physician
Schonfeld, Yisroel

**ICD-10 CM Principal Diagnosis: S06.5X1D. Traum subdr hem w LOC of 30 minutes or less subs**

**Other Pertinent Diagnoses**

| ICD-10 CM | Description | Medications |
|---|---|---|
| E11.22 | Type 2 diabetes mellitus w diabetic chronic kidney disease | Ammonium Lactate - Ammonium Lactate External Cream 12 % / Apply to Both legs/feet topical once a day for Dry Skin<br>CYANOCOBALAMIN 1000 MCG / 1 Tablet by mouth one time a day for Anemia<br>Eyelid Cleansers External Pad (Eyelid Cleansers) Apply to both eyes topical in the morning for Crust around the eyes<br>Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) MG / 1 Tablet by mouth twice a day for Anemia<br>FOLIC ACID 1 MG / 1 Tablet by mouth one time a day for Anemia<br>Tums - Simethicone Chewable 500 MG / 1 Tablet by mouth as necessary every 4 hours for indigestion<br>Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox Tablet Give 1000 unit by mouth one time a day related to ANEMIA, UNSPECIFIED (D64.9)<br>Bactrim Ds - Sulfamethoxazole: Trimethoprim 800 mg;160 mg 800/160mg by mouth every 12 hours Skin infection |
| N18.9 | Chronic kidney disease unspecified | |
| D63.1 | Anemia in chronic kidney disease | |
| N39.0 | Urinary tract infection site not specified | |
| E55.9 | Vitamin D deficiency unspecified | |
| Z87.891 | Personal history of nicotine dependence | |
| Z86.711 | Personal history of pulmonary embolism | |
| Z91.81 | History of falling | |

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|---|---|
| **Prognosis**<br>fair | **Mental and Psychosocial Status**<br>COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: , SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION: |
| **Functional Limitations**<br>Endurance | **Activities Permitted**<br>Up As Tolerated, Cane |
| **DME & Supplies**<br>cane | **Safety Measures**<br>no reaching, 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 |
| **Nutrition**<br>Z. NO PHYSICIAN-ORDERED DIET | **Allergies**<br>no known allergies |

| Advance Directives | Caregiver Status |
|---|---|
| SEE MOLST | 1. Non-agency caregiver(s) currently provide assistance |
| **Rehabilitation Potential** | **DISCHARGE PLAN:** |
| SELF-CARE: , MOBILITY: | SN: patient will be responsible for managing treatment |

**Orders for Discipline and Treatment:**
4 - Recertification SN

## SN CAREPLAN

SN frequency WK1: 1 (10/25/26-10/31/26),WK2: 1 (11/01/26-11/07/26),WK3: 1 (11/08/26-11/14/26),WK4: 1 (11/15/26-11/21/26),WK5: 1 (11/22/26-11/28/26),WK6: 1 (11/29/26-12/05/26)

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: 9. Other risk(s) not listed in 1- 8

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.

Left wound cleanse pat dry wrap with kerlix daily
Advance Directive:SEE MOLST

10/26/2026 Problems : #1 - Other - Anterior Left Foot - Bruising no open wound
balance deficit
swelling in the arms/legs
dependent edema
swelling of affected area
swell/redness surround. skin

PROCEDURES: physician-ordered wound care: #1 - Other - Anterior Left Foot - Bruising no open wound: Cleanse wound pat dry wrap with kerkix daily, monitor intake & output

TEACH PATIENT/CAREGIVER: * 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

## SN NARRATIVE

Start time 1:34pm

Recert

Patient alert and oriented x3. Patient evaluated at Mercy Hospital for wound to left foot/amputated big toe. Patient prescribed antibiotics Bactrim DS for skin infection every 12 hours daily for x7 days per discharge paper work. Patient has 10 days worth of medicine. Patient to follow up with nephrology and provider. Provider visit scheduled for 10/29 @ 2:30p for hospital follow up visit. Antibiotic education provided to patient to complete antibiotic regimen. Patient instructed to eat before administering antibiotic. Possible GI irritation with possible soften stools. Patient denies pain. Left foot wound care. Cleanse wound pat dry wrap in kerlix and secure with tape. No drainage noted bruising 2x1.5cm beneath big toe area. Point of care glucose 101. Dependent edema to Bilateral lower extremities. Patient instructed on compression wear. Patient has compression stockings. Nurse demonstrated and applied compression wear to feet. No discomfort reported. Patient instructed to remove with sleep with elevated legs when th sitting and laying. Patient states understanding. Labs reviewed with patient with Abnormal kidney results with referral to nephrology. Patient reports he was unable to remember to let great toe amputation. Patient reports he was reminded by his daughter of past lawn mower accident that cause injury. Patient appeared relieved. Patient recounting past event to present day. Patient caregiver is sister Denise and his daughter. Patient reports he is well taken care of. No falls reported. Patient received call from nurse Lisa to assess condition after ER evaluation. Nurse was able to report follow up instructions discussed with and patient reports understanding. SN frequency 1w6.

## SN GOALS

PATIENT-STATED GOAL: To get back healthy and in shape

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
* 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

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Townes, McLeod | Cert Period 10/25/26 - 12/23/26

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|---|---|
| | **PT NARRATIVE**<br>Client is a 75 year old with recent discharge from rehabilitation facility where he spent several months post fall with SDH. History includes DM, CKD, UTI, PE, FALLS, LEFT FOOT WITH 3 TOES AMPUTATED, ANEMIA. Ambulates on indoor surface without device and supervision 40 feet x 2 with increasedtrunk flexion. Ambulates on outside unlevel cement one block without device and close supervision with trunk flexion. Performs 7 steps with rail and supervision to exit. Bed mobility is independent. Transfers to bed, chair, toilet with supervision. Therapist did not assess car transfer. Client tolerated 10 reps of supine hip flexion, bridging, straight leg raise, hip abduction , standing knee flexion, hip abduction, hip extension, plantarflexion, squats, sitting knee extension, ankle pumps. Client is homebound due to significant effort to leave home and as evidenced by tinetti score of 23/28. Client would benefit from home therapy to increase strength and improve posture and improve functional mobility. Lives with sister in basement apartment. |

**Signature and Date of Verbal SOC Where Applicable:**
Electronically signed by: Charles Messick RN on 10/21/2026

| | |
|---|---|
| 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.<br>F2F date: 08/03/2026 | 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** **Yisroel Schonfeld**<br>301 St Paul Pl<br>Baltimore, MD 21202<br>NPI 1033634431 | **Phone Number** 4103327460<br><br>**Fax Number** 14103329669 |

**Physician's Signature and Date Signed**

**X**

**Yisroel Schonfeld, PA**
08/03/2026: Date of physician last face-to-face