Home Health Certification and Plan of Care

Order ID: 1150/12816

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1JV7N60KW72	09/26/2025	From: 09/26/2025 To: 11/23/2025	17506	217058

6. Patient's Name and Address
Diane Tosic
6214 Ridgeview Avenue,
BALTIMORE, MD 21206-
443-558-8264

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 02/02/1933 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
L89.310	Pressure ulcer of right buttock unstageable	09/26/25

13. ICD	Other Pertinent Diagnoses	Date
L89.100	Pressure ulcer of unspecified part of back unstageable	09/26/25
L89.890	Pressure ulcer of other site unstageable	09/26/25
I10.	Essential (primary) hypertension	09/26/25
K21.9	Gastro-esophageal reflux disease without esophagitis	09/26/25
F01.A0	Vascular dementia mild without beh/psych/mood/anx	09/26/25
M19.90	Unspecified osteoarthritis unspecified site	09/26/25
M79.7	Fibromyalgia	09/26/25
H40.9	Unspecified glaucoma	09/26/25
H81.10	Benign paroxysmal vertigo unspecified ear	09/26/25
Z74.01	Bed confinement status	09/26/25
Z86.018	Personal history of other benign neoplasm	09/26/25

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

Tylenol - Acetaminophen 500 MG , Take 2 tablets by mouth three times a day Take 2 tablets (1,000 mg total) by mouth 3 (three) times a day as needed for pain Indications
Dulcolax - Bisacodyl 10 mg , Insert 1 suppository rectal once a day Insert 1 suppository (10 mg total) into the rectum daily as needed for constipation Indications: constipation,
emptying of the bowel. - rectal
Acetaminophen - Acetaminophen 500mg by mouth three times a day Taken as needed for pain.
Aspirin 81Mg - Aspirin 81 MG , Take 1 tablet by mouth once a day Take 1 tablet (81 mg total) by mouth daily for blood thinner
Senna - Senna 8.6mg by mouth once a day "I give her one a day because two gives her diarrhea"
Carafate - Sucralfate 1 gram , Take 1 tablet by mouth four times a day Take 1 tablet (1 g total) by mouth 4 (four) times a day Indications: a stomach ulcer. Caregiver verbalized understanding
Ultram - Tramadol Hydrochloride 50 mg 50 mg , Take 0.5-1 tablets by mouth every 6 hours Take 0.5-1 tablets (25-50 mg total) by mouth every 6 (six) hours as needed for pain. Caregiver verbalized understanding
Protonix - Pantoprazole Sodium eq 40 mg base 40 MG , Take 1 tablet by mouth twice a day Take 1 tablet (40 mg total) by mouth 2 (two) times a day Indications: a stomach ulcer. Caregiver verbalized understanding
Docusate Sodium - Docusate Sodium 100mg by mouth once a day Stool softener
A+D ointment Topical topical once a day Used daily after bed bath

14. DME and Supplies:
wound care supplies, Dry Gauze , Normal saline, Calcium alginate

15. Safety Measures:
bathroom safety, , , infectious material management, , , hand rails, smoke detectors , , bedrails up while in bed

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
penicillin shellfish

18.A. Functional Limitations
Endurance, Dyspnea With Minimal Exertion, Bowel/Bladder Incontinence

18.B. Activities Permitted
None of the above

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 1. Rarely, 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: No

20. Prognosis: poor

22. A Rehabilitation Potential:
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans
family/caregiver will be responsible for managing treatment

Homebound status:
Due to diagnosis of Pressure Ulcer Of Right Buttock Unstageable , 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 92-year-old female who is alert and oriented to person, place, and time (A&O3). She is completely bedbound and entirely dependent on her live-in caregiver, Karen, for all activities of daily living (ADLs) and medication administration. The patient was previously on hospice care but has since been discharged and is no longer receiving hospice services. According to the caregiver, the patient refuses to leave her home under any circumstances; therefore, all medical care must be provided in the home setting. During the nursing assessment, the patient was minimally communicative but responsive when engaged. Her primary health concerns include multiple chronic wounds of varying severity. The most significant wound is located on the mid-back, which was noted to be draining purulent material, suggestive of infection, and associated with considerable pain. A second wound on the right buttock appeared irritated but produced minimal drainage. Additionally, a chronic wound on the lateral aspect of the left arm was observed to be oozing blood; the caregiver reported this wound has been persistent for an extended period without successful treatment outcomes despite prior medical evaluations. Physical examination revealed bilateral lower extremity and elbow swelling with associated inflammation, which the caregiver stated represents the patient's baseline condition. The patient appeared frail and required maximal assistance for repositioning in bed to maintain comfort and prevent further skin breakdown. The caregiver demonstrated strong knowledge of the patient's medications, including dosing, administration schedule, and indications. She reliably administers all prescribed medications as ordered. Following the assessment, the registered nurse (RN) contacted the patient's primary care physician to discuss wound status and care needs. Updated wound care orders were entered into the patient's medical record. The physician scheduled a home visit for the upcoming Monday to personally reassess the patient's wounds, and the RN will attend that visit to assist with evaluation and coordinate ongoing care. The plan of care includes continued wound monitoring, reinforcement of infection prevention measures, caregiver education on wound care and repositioning techniques, and close communication with the healthcare team to address any changes in the patient's condition promptly.
 Date of Order 09/26/2025 Orders Physician Face-to-Face Date: 09/02/2025 Clinical Condition Requiring Home Care per

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 09/26/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Michael Kingan
5210 Eastern Avenue
Baltimore, MD 21224
PHONE: 4438493184 FAX: 14438498367 NPI: 1861871881

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 : 09/02/2025

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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Certifying Physician: SN disease management due to Pressure Ulcer Of Right Buttock Unstageable 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 Kingan, Michael

SN Careplans

SN WK1: 1 (09/26/25-09/27/25) ,WK2: 1 (09/28/25-10/04/25) ,WK3: 2 (10/05/25-10/11/25) ,WK4: 1 (10/12/25-10/18/25) ,WK5: 1 (10/19/25-10/25/25) ,WK6: 1 (10/26/25-11/01/25) ,WK7: 1 (11/02/25-11/08/25) ,WK8: 1 (11/09/25-11/15/25)

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: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 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; 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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M1745 - Behavioral Issues, M1700 - Cognition, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, M1400 - Dyspnea, M1620 - Bowel Incontinence, constipation, limited strength, limited endurance, poor muscle tone, muscle weakness, limited range of motion, B1000 - Vision Deficit, balance deficit, weak hand grips, lethargy, Pain Effect on Sleep, bleeding/discharge at site, discolored patches of skin, open sores/lesions, red/tender pressure points, #1 - 6 - Unstageable due to coverage of wound bed by slough and/or eschar. - Posterior Right Middle/Lower Back - *Depth of wound is undetermined * Wound Care Orders - Mid-Lower Back: -Cleanse the wound with VASH wound cleanser or normal saline at each dressing change. -Apply silver hydrofiber or calcium alginate to the wound base. -Place a 4x4 dressing over the wound for additional absorption. -Cover with an adhesive foam dressing. -Change the dressing daily, or sooner if drainage covers 75% or more of the dressing., #2 - 6 - Unstageable due to coverage of wound bed by slough and/or eschar. - Posterior Right Buttock - Cleanse the wound with normal saline every other day. Cover with gauze. **Oder may be updated per Dr , #3 - Open Wound - Posterior Left Upper Arm - Wet to dry dressing

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, physician-ordered wound care: Wound Care Orders - Mid-Lower Back: -Cleanse the wound with VASHE wound cleanser or normal saline at each dressing change. -Apply silver hydrofiber or calcium alginate to the wound bed. -Place a 4x4 dressing over the wound for additional absorption. -Cover with an adhesive foam dressing. -Change the dressing daily, and PRN if drainage covers 75% or more of the dressing. To right buttock wound- Cleanse the wound with normal saline, Cover with gauze. change every other day. To left upper arm wound- Wet to dry dressing. Change-as needed., teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver, 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 increase caloric intake, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * low-fat diet lifestyle modifications to manage esophageal condition, related medication(s) purpose, schedule, * how to manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using

SN Goals

PATIENT-STATED GOAL: "to stay out of the hospital and just feel better"

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
* low-fat diet
* lifestyle modifications to manage esophageal condition
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* 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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

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
* how to keep home safe for patient with dementia
* coping strategies for the caregiver
* 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/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/26/2025

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mechanical aids, 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

hazards
* enhancing lighting
* using mechanical aids

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

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

patient is adequately supervised

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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