Home Health Certification and Plan of Care

Order ID: 1150/12860

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
78345454	09/26/2025	From: 09/26/2025 To: 11/24/2025	17854	217058

6. Patient's Name and Address
Makins Flahn
2600 Essex Rd Apt 104,
GWYNN OAK, MD 21207-
609-933-6592

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 05/03/1996 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
O86.09	Infection of obstetric surgical wound other surgical site	09/26/25

13. ICD	Other Pertinent Diagnoses	Date
K65.1	Peritoneal abscess	09/26/25
K65.9	Peritonitis unspecified	09/26/25
B96.20	Unsp Escherichia coli as the cause of diseases classd elswhr	09/26/25
D64.9	Anemia unspecified	09/26/25
K59.09	Other constipation	09/26/25
E66.01	Morbid (severe) obesity due to excess calories	09/26/25
Z68.41	Body mass index [BMI] 40.0-44.9 adult	09/26/25
Z45.2	Encounter for adjustment and management of VAD	09/26/25
Z79.2	Long term (current) use of antibiotics	09/26/25
Z79.82	Long term (current) use of aspirin	09/26/25
Z79.891	Long term (current) use of opiate analgesic	09/26/25

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

Pepcid - Famotidine 20 mg, Take 1 tablet by mouth twice a day Take 1 tablet by mouth daily 30 minutes before breakfast and dinner. Patient able to state why she is taking the medicine.
Motrin - Ibuprofen 800 mg, Take 1 tablet by mouth every 8 hours Take 1 tablet by mouth every 8 hours as needed for moderate pain. Take with food. Patient understands purpose, dosage and freq of medicine.
Roxicodone - Oxycodone Hydrochloride 5 mg, Take 2 tablets by mouth every 6 hours Take 2 tablets by mouth every 6 hours as needed for moderate pain. Patient is able to state the purpose, dosage s/e, freq of medicine.
Zofran - Ondansetron Hydrochloride 4 mg, Take 1 tablet by mouth as necessary Take 1 tablet by mouth every 8 hours as needed for nausea. Patient reports no nausea or vomiting and states she knows when to take the medicine.
Folvite - Folic Acid 400 mcg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily.. Patient able to state medicine is a vitamin supplement.
Dulcolax - Bisacodyl 5 mg, Take 1 table by mouth once a day Take 1 tablet by mouth daily. Patient reports taking the medicine only if she needs it. She is currently having daily BMs.
Invanz - Ertapenem Sodium 500 mg intravenous once a day IV antibiotic administrated by IV nurse from another company until 10/102025 daily. Patient neds teaching of med.

14. DME and Supplies:
IV supplies, wound care supplies, wound vac & dressings

15. Safety Measures:
infectious material management, , no bp right arm, , , transfer with assist,

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Up As Tolerated

19. Mental & Pyschosocial 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: 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

Homebound status: Due to diagnosis of Infection Of Obstetric Surgical Wound, Other Surgical Site, 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 29-year-old African American female, alert and oriented 4, recently status post cesarean section complicated by postoperative infection. She resides in a two-bedroom apartment with her spouse and two-week-old infant daughter. At the time of visit, she was observed sitting on the sofa with her infant safely positioned in a bassinet beside her, supported by pillows. The patient appeared edematous, with noticeable swelling of the abdomen, legs, and feet. A peripherally inserted central catheter (PICC) line was noted in the right antecubital space, and she reported that the visiting IV nurse was scheduled to arrive later in the day, though she was unsure of the exact time. The patient stated that her cesarean delivery occurred on September 12, 2025. After returning home, she began experiencing sharp abdominal pain and fever within several days, prompting evaluation at an urgent care center. She was subsequently admitted to the hospital on September 19, 2025, where an exploratory laparotomy was performed, revealing an E. coli infection in the peritoneal cavity. She was started on intravenous antibiotics and discharged on September 25, 2025, to continue IV therapy at home. She is currently breastfeeding and pumping milk for her infant, reports minimal lochia, regular bowel movements, adequate urine output, and fair appetite. Her spouse assists with both infant and maternal care. The patient requires her husband's help to rise from bed or sofa but is able to ambulate independently once standing. Medication reconciliation was completed using the hospital discharge chart and electronic record, with corrections made as necessary. The patient demonstrated understanding of her current medication regimen. Vital signs were within normal limits. Physical examination revealed non-pitting edema of both lower extremities and a distended abdomen. A wound vacuum-assisted closure (VAC) device was in place over the lower abdominal incision, draining serosanguinous fluid; the canister was approximately half full. The midline surgical incision, secured with 12 staples, measured approximately 8 cm 0.1 cm 0.1 cm, with intact skin and no signs of infection. The left lower quadrant contained a Jackson-Pratt (JP) drain secured with black sutures, producing clear, blood-tinged drainage. A small right lower quadrant opening was noted at the site of a previous JP removal. During wound care, the wound VAC was temporarily disconnected to replace the canister and change the dressing. The black foam dressing was removed from the cervical wound with some difficulty due to adherence, causing significant discomfort despite the patient having taken oxycodone one hour prior. The wound was cleansed with normal saline, revealing a beefy red tissue bed measuring approximately 2 cm (L) 14 cm (W) 2 cm (D). The

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
Nkechinyerem Eseonu Ewoh
7070 Samuel Morse Dr
Columbia, MD 21246
PHONE: FAX: NPI: 1114247541

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 : 09/24/2025

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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surrounding skin appeared intact and healthy. Using aseptic technique, the wound and periwound area were cleansed, drape dressing was applied, and new black foam was inserted into the wound cavity and bridged toward the umbilicus. The wound VAC was reconnected and restarted after troubleshooting a suction issue, successfully achieving negative pressure at 125 mmHg. The patient reported increased pain once suction was established. Comprehensive education was provided on wound VAC management, including the rescue dressing procedure and emergency contact information. The patient and her spouse were instructed on canister replacement and monitoring for drainage changes, signs of infection, and device malfunction. The spouse demonstrated understanding of all instructions. The plan of care includes continued skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> for wound management, monitoring of infection and healing progression, IV antibiotic administration oversight, pain management support, and reinforcement of postpartum education including mobility safety, nutrition, and rest to promote recovery and prevent complications.
 Date of Order 09/26/2025 Orders Physician Face-to-Face Date: 09/24/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-wound mangement due to Infection Of Obstetric Surgical Wound, Other Surgical Site 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 Eseonu Ewoh, Nkechinyerem

SN Careplans

SN WK1: 1 (09/26/25-09/27/25) ,WK2: 3 (09/28/25-10/04/25) ,WK3: 3 (10/05/25-10/11/25) ,WK4: 3 (10/12/25-10/18/25) ,WK5: 3 (10/19/25-10/25/25) ,WK6: 3 (10/26/25-11/01/25) ,WK7: 2 (11/02/25-11/08/25)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 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
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, weak pulses in feet, swelling in the arms/legs, limited strength, limited endurance, swelling of affected area, Pain Effect on Sleep, Pain Interference with ADLs, swell/redness surround. skin, #1 - Observable Surgical Wound - Other - Pelvic C-section - Tissue red, draining large amount serosanguinous secretions. Wound vac intact, #2 - Observable Surgical Wound - Other - Midline Abodmen - Closed with staples

PROCEDURES: Medication review: Medications to be reviewed on each visit for changes., cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: Nurse to remove abdominal staples when staple removal kit is in the home on next visit. Notify MD of any s/s of infection, physician-ordered wound care: To abdominal surgical site and JP drain sites. Cleanse with normal saline, pat dry, apply dry clean dressing. Change with each wound vac change and as needed. Staples to be removed at Physician office., wound vacuum: To lower abdomen wound site- Change of wound vac MWF with black granuform. NPWT pressure 125 mm/Hg. If NPWT device is not functioning normally, contact managing services or ordering provider for assistance. If issue not resolved in 2 hrs, remove the device and NPWT dressing entirely. Apply rescue dressing of NSS moistened gauze until the NPWT can be reapplied., infusion therapy: Infusion is done by another IV company.

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, * lifestyle modification to manage blood condition including dietary changes bleeding precautions, 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, TBD, * how to help resolve infection including hygiene proper hand washing food-safety techniques travel precautions vaccinations animal-control cough etiquette, 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, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: Wound to heal.

GOALS
TBD

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
* how to help resolve infection including hygiene
* proper hand washing
* food-safety techniques
* travel precautions
* vaccinations
* animal-control
* cough etiquette
* 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
* 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

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* 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

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/26/2025