Home Health Certification and Plan of Care

Order ID: 1150/13731

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
69116927	10/31/2025	From: 10/31/2025 To: 12/28/2025	19058	217058

6. Patient's Name and Address
Jason Levitt
2652 Emma Stone Dr,
MARRIOTTSVILLE, MD 21104-
443-876-7626

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 03/29/1981 | 9.Sex Male

11. ICD	Principal Diagnosis	Date
K92.2	Gastrointestinal hemorrhage unspecified	10/31/25

13. ICD	Other Pertinent Diagnoses	Date
E11.9	Type 2 diabetes mellitus without complications	10/31/25
I95.9	Hypotension unspecified	10/31/25
K70.11	Alcoholic hepatitis with ascites	10/31/25
D68.4	Acquired coagulation factor deficiency	10/31/25
K76.6	Portal hypertension	10/31/25
G89.4	Chronic pain syndrome	10/31/25
F31.9	Bipolar disorder unspecified	10/31/25
F17.290	Nicotine dependence other tobacco product uncomplicated	10/31/25
Z93.3	Colostomy status	10/31/25
Z93.2	Ileostomy status	10/31/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	10/31/25

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

Oyster Shell - Calcium Acetate 250 mg-3.125 mcg (125 unit), Take 1 tablet by mouth once a day Take 1 tablet by mouth 1 (one) time each day with breakfast.
Neurontin - Gabapentin 300 mg, Take 2 capsules by mouth at bedtime
Chronulac - Lactulose Take 30 mL (20 g total) by mouth once a day Take 30 mL (20 g total) by mouth 1 (one) time each day in the evening.
Protonix - Pantoprazole Sodium 40 mg EC tablet, Take 1 tablet by mouth twice a day Take 1 tablet (40 mg total) by mouth 2 (two) times a day before meals. Do not crush, chew, or split.
Folvite - Folic Acid 1 mg 1 mg , Take 1 tablet by mouth once a day Supplement
Neurontin - Gabapentin 300 mg 300 mg, Take 1 capsule by mouth twice a day 4 caps daily for nerve pain
Inderal - Propranolol Hydrochloride 40 mg 10 mg , Take 1 tablet (10 mg total by mouth twice a day Taking g for htn
Proamatine - Midodrine Hydrochloride 5 mg 10 mg , Take 1 tablet (10 mg total) by mouth three times a day For hypotension
Aldactone - Spironolactone 50 mg 50 mg, Take 1 tablet (50 mg total) by mouth once a day "Helps me pee"
Sodium Chloride - Sodium Chloride 1 gram, Take 2 tablets (2 g total) by mouth three times a day Take 2 tablets (2 g total) by mouth 3 (three) times a day with meals.
Zofran Odt - Ondansetron 4 mg 4 mg disintegrating tablet, Take 1 tablet by mouth every 8 hours Take 1 tablet (4 mg total) by mouth every 8 (eight) hours if needed for vomiting or nausea for up to 7 days.
Roxicodone - Oxycodone Hydrochloride 10 mg 10 mg immediate release,Take 0.5 tablets (5 mg total) by mouth every 6 hours Take 0.5 tablets (5 mg total) by mouth every 6 (six) hours if needed for severe pain or moderate pain. Max Daily Amount: 20 mg
Lantus - Insulin Glargine Recombinant 100 units/ml 16 units subcutaneous once a day for blood sugar control
Humalog - Insulin Lispro Recombinant 100 units/ml per sliding scale

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Johnson, Abigail SN RN on 10/31/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Alicia Lee
7070 Samuel Morse Dr
Columbia, MD 21046
PHONE: 4103094600 FAX: 14103093357 NPI: 1194023929

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 : 10/28/2025

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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subcutaneous as necessary Use sliding scale; Administer 3 times a day 15 minutes before meals if blood sugar is more than 130 mg/dL: If 131-160mg/dL: add 1 unit; If 161-190mg/dL: add 2 units; If 191-220mg/dL: add 3units; If 221-250mg/dL: add 4 units; If 251mg/dL to280mg/dL add 5 units; If 281-310mg/dL add 6 units; If 311-340mg/dL add 7units. If above 340mg/dL add 8 units. Please notify prescriber if requiring up to 20 units daily. Call Advice Nurse if blood sugar is less than 70mg/dL or more than 400mg/dL. Hold insulin if below 130mg/dL before meal. (Max of 20 units per day)

14. DME and Supplies:
ostomy supplies, walker

15. Safety Measures:
infectious material management, sharps precautions, bathroom safety, diabetic precautions, medication safety, fall precautions, ambulates with device, walker precautions, transfer with assist, supervision at all times, bedrails up while in bed, ambulates with assistance, anticoagulant precautions, standard precautions

16. Nutrition:
2gm sodium, cardiac diet

17. Allergies:
no known allergies

18.A. Functional Limitations
Dyspnea With Minimal Exertion, Ambulation

18.B. Activities Permitted
Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A 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.

22.B.Discharge Plans
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Gastrointestinal hemorrhage unspecified, 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 44-year-old male with a complex medical history including alcoholic cirrhosis, portal hypertension, gastropathy, esophageal and stomal varices (status post banding), anemia, chronic hypotension, type 2 diabetes, and bipolar disorder. He has a right-sided end colostomy following emergency surgery for a gastrointestinal bleed in January and was most recently hospitalized from 10/25-10/28/25 for recurrent GI bleeding secondary to varices, coagulopathy, and ascites. On assessment, the stoma was clean and intact with colostomy output containing a mixture of blood and stool, which the patient reports fluctuates based on food intake. A stage 1 pressure ulcer was noted on the sacral area with partial skin involvement; the patient will follow up with his physician for wound care orders. He lives with his parents, who assist with daily care, and ambulates short household distances using a rolling walker with minimal assistance. Vital signs were stable, and orthostatic tendencies were noted with mild dizziness on standing. The patient presents with significant deconditioning, generalized weakness, and limited endurance, which restrict his ability to ambulate safely and perform activities of daily living independently. He requires contact guard assistance for upper body dressing and moderate assistance for lower body dressing, bathing in bed, and toilet transfers. His primary goal is to "get stronger and walk safely again," with an additional goal of returning to showering. Skilled nursing will continue to monitor his medical status and coordinate with physical and occupational therapy. The therapy plan includes gait and transfer training, strengthening, endurance and balance exercises, and education on pacing, energy conservation, and orthostatic symptom management. With consistent family support and rehabilitation participation, the patient demonstrates good potential to regain functional mobility and progress toward increased independence.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 10/31/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 10/28/2025
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Gastrointestinal hemorrhage unspecified
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval Notes:
 OT Eval Notes:<o:p></o:p> Physician: Lee, Alicia

SN Careplans

SN WK1: 1 (10/31/25-11/01/25) ,WK2: 2 (11/02/25-11/08/25) ,WK3: 2 (11/09/25-11/15/25) ,WK4: 1 (11/16/25-11/22/25) ,WK5: 1 (11/23/25-11/29/25) ,WK6: 1 (11/30/25-12/06/25)

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: 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; 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

SN Goals

PATIENT-STATED GOAL: "To get a liver transplant and a stoma reversal"

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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Johnson, Abigail SN RN

Date
10/31/2025

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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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0700 - Social Isolation, M2020 - Oral Med Management, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, tarry/bloody stools, poor muscle tone, limited endurance, limited strength, limited range of motion, muscle weakness, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, loss of appetite, M1630 - GI Ostomy, bleeding/discharge at site, #1 - Open Wound - Posterior Sacrum -

PROCEDURES: Medication Review- : Medication reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: Awaiting physicians wound care orders, apply collection/fistula pouch, ostomy care & irrigation, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals, venipuncture: Skilled nurse to draw labs every 2 weeks: CBC, LFT, Chem 7, PT/INR, GGT, Phosphatidylethanol Level (PEth) . Drop off specimens at a Kaiser Lab. Results to Dr. Alicia Lee.

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, * 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 achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * GI-specific diet including appropriate food choices stress management exercise home remedies to manage GI condition, related medication(s) purpose, schedule, * ostomy management including how to clean stoma change ostomy pouch, related medication(s) purpose, schedule, * dietary modifications for liver disorder, 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, * strategies to increase socialization, 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

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

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

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls
* GI-specific diet including appropriate food choices
* stress management
* exercise
* home remedies to manage GI condition
* 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
* dietary modifications for liver disorder
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* ostomy management including how to clean stoma
* change ostomy pouch
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 2 (11/02/25-11/08/25) ,WK3: 2 (11/09/25-11/15/25) ,WK4: 2 (11/16/25-11/22/25) ,WK5: 1 (11/23/25-11/29/25) ,WK6: 1 (11/30/25-12/06/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object

PROCEDURES: HEP: Seated marching - 10-15 reps 2 sets Long arc quads - 10-15 reps 2 sets Ankle pumps/circles - 20 reps hourly to improve circulation Sit-to-stand from chair - 5-10 reps as tolerated, focusing on controlled movement Standing heel/toe raises with walker support - 10 reps 2 sets Education provided on pacing, breathing control, and rest breaks to prevent fatigue. Advised to perform exercises 2-3 times daily as tolerated and

PT Goals

PATIENT-STATED GOAL: To be able to traverse stairway safely

GOALS
Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

Car Transfer - 04. Supervision or touching assistance

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 3 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Johnson, Abigail SN RN	10/31/2025

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to stop if dizziness, pain, or excessive fatigue occurs., B LE strengthening, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

OT Careplans

OT WK2: 1 (11/02/25-11/08/25) ,WK3: 1 (11/09/25-11/15/25) ,WK4: 1 (11/16/25-11/22/25) ,WK5: 1 (11/23/25-11/29/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

PROCEDURES: ADLs , Functional ambulation , Patient/caregiver recalls related purpose and schedule of medications: Medications Review , cough/deep breathing exercises, transfers training, therapeutic 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, Oral Hygiene - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Shower/Bathe Self - 05. Setup or clean-up assistance, Toileting Hygiene - 01. Dependent, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Patient will demonstrate improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

OT Goals

PATIENT-STATED GOAL: Patient wants to get stronger and walk better

GOALS
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

Oral Hygiene - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Toileting Hygiene - 01. Dependent

Don/Doff Footwear - 05. Setup or clean-up assistance

Patient will demonstrate improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

Eating - 06. Independent

HHA Careplans

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PROCEDURES: assist with bathing: Bed bath or bathe in shower, assist with toilet transferring, assist with toileting hygiene, assist with transferring, assist with mobility, assist with infection control, assist with fall prevention, assist with lower body dressing, assist with upper body dressing

HHA Goals

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Johnson, Abigail SN RN	10/31/2025