

Home Health Certification and Plan of Care				Order ID: 1150/14332		
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: 11/24/2025 To: 01/22/2026		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			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			
11. ICD L89.310 Principal Diagnosis Pressure ulcer of right buttock unstageable Date 09/26/25						
13. ICD L89.100 L89.890 I10. K21.9 F01.A0 M19.90 M79.7 H40.9 H81.10 Z74.01 Z86.018 Other Pertinent Diagnoses Pressure ulcer of unspecified part of back unstageable Pressure ulcer of other site unstageable Essential (primary) hypertension Gastro-esophageal reflux disease without esophagitis Vascular dementia mild without beh/psych/mood/anx Unspecified osteoarthritis unspecified site Fibromyalgia Unspecified glaucoma Benign paroxysmal vertigo unspecified ear Bed confinement status Personal history of other benign neoplasm Date 09/26/25 09/26/25 09/26/25 09/26/25 09/26/25 09/26/25 09/26/25 09/26/25 09/26/25 09/26/25						
14. DME and Supplies: wound care supplies			15. Safety Measures: bedrails up while in bed, activity supervision, , supervision at all times			
16. Nutrition: low cholesterol, low sodium			17. Allergies: penicillin shellfish			
18.A. Functional Limitations Bowel/Bladder Incontinence, Endurance, Ambulation			18.B. Activities Permitted Complete Bedrest			
19. Mental & Pyschosocial Status: COGNITION: 4. Is totally dependent in toileting., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:						
20. Prognosis: fair						
22. A Rehabilitation Potential: SELF-CARE: , MOBILITY:			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: <div>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.&nbsp;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.&nbsp;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.&nbsp;The caregiver demonstrated strong knowledge of the patient's medications, including dosing, administration schedule, and indications. She reliably administers all prescribed medications as ordered.&nbsp;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.&nbsp;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.</div><div></div><div>11/19/2025</div><div>Orders</div><div>Physician Face-to-Face Date: 09/02/2025</div><div>Clinical Condition Requiring Home Care per Certifying Physician: SN disease management due to Pressure Ulcer Of Right Buttock Unstageable</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div></div><div>4 - Recertification Notes: Back wound with pain with packing wound care required to prevent infection and promote healing with immobility making it a taxing effort to leave the home. Requesting 2 additional nurse to continued closure of back wound.&nbsp;&nbsp;&nbsp;</div><div>Physician</div><p class="p1" style="margin-bottom: 0px;>						

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font-variant-numeric: normal; font-variant-east-asian: normal; font-variant-alternates: normal; font-size-adjust: none; font-kerning: auto; font-optical-sizing: auto; font-feature-settings: normal; font-variation-settings: normal; font-variant-position: normal; font-variant-emoji: normal; font-stretch: normal; font-size: 13px; line-height: normal;">Kingan, Michael				

SN Careplans SN WK1: 1 (11/24/25-11/29/25) ,WK2: 1 (11/30/25-12/06/25) ,WK3: 1 (12/07/25-12/13/25) ,WK4: 1 (12/14/25-12/20/25) 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:Living Will PROBLEMS IDENTIFIED ON ASSESSMENT: abn cholesterol > 200 mg/dL, abnormal blood pressure, swelling of affected area, loss of appetite, skin breakdown r/t incontinence 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: * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * 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 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	SN Goals PATIENT-STATED GOAL: "to stay out of the hospital and just feel better" GOALS 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 * how to take the patient's blood pressure * record the reading * 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 * how to keep home safe for patient with vision loss including eliminating hazards * enhancing lighting * using mechanical aids 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 * strategies to increase caloric intake * 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 * how to keep home safe for patient with dementia * coping strategies for the caregiver * recalls related medication(s) purpose, schedule patient/caregiver recalls * bowel incontinence management including dietary changes * bowel training * skin care * 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 self-administers medications as prescribed * recalls 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 patient/caregiver recalls * prevention exacerbation of anxiety condition including coping patterns * improved concentration * strategies to reduce anxiety * identification of anxiety precipitants, conflicts, and threats
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/19/2025

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		* 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 * 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		

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