Home Health Certification and Plan of Care

Order ID: 1150/16322

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
51356144	02/16/2026	From: 02/16/2026 To: 04/16/2026	22569	217058

6. Patient's Name and Address
Melvin Dinkins
7532 Monarch Mills Way,
Columbia, MD 21045-
973-986-1966

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 10/04/1969 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I71.00	Dissection of unspecified site of aorta	02/16/26

13. ICD	Other Pertinent Diagnoses	Date
Z48.812	Encntr for surgical aftcr following surgery on the circ sys	02/16/26
I46.9	Cardiac arrest cause unspecified	02/16/26
I15.9	Secondary hypertension unspecified	02/16/26
Z79.82	Long term (current) use of aspirin	02/16/26

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

Pacerone - Amiodarone Hydrochloride 200 mg / 1 Tablet by mouth once a day
Norvasc - Amlodipine Besylate eq 2.5 mg base / 1 Tablet by mouth once a day
Aspirin 81Mg - Aspirin / 1 Tablet by mouth once a day
Normodyne - Labetalol Hydrochloride 200 mg / 1 Tablet by mouth every 8 hours
Tylenol - Acetaminophen 500 mg / 1 Tablet by mouth every 8 hours Take 2 tablets for 10 days
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 mg immediate release / 1 Tablet1 by mouth every 6 hours as needed for Pain
Furosemide - Furosemide 20 mg / 1 Tablet by mouth once a day for 7 days
Protonix - Pantoprazole Sodium 0 EC 40 mg / 1 Tablet by mouth once a day
Lipitor - Atorvastatin Calcium eq 40 mg base eq 40 mg base / 1 Tablet by mouth in the evening

14. DME and Supplies:
None of the above

15. Safety Measures:
no straining, standard precautions, supervision at all times, fall precautions, bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:
cardiac diet, low cholesterol, low sodium

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: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., 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 Dissection of unspecified site of aorta, 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: Start of care completed for a 56-year-old male referred to home health status post thoracic aortic dissection repair for aneurysm, who requires supervision for safety, making it a taxing effort to leave the home. Paper consent was obtained due to technical difficulties. Assessment revealed a 5.5 cm right groin incision and a 16 cm midline chest incision, both open to air, as well as a small (<1 cm) site beneath the midline incision from a prior chest tube; no wound care is currently ordered. The patient reports chest pain rated 5/10 or less with position changes, laughing, and coughing, and is managing pain with acetaminophen while declining prescribed analgesics; he was instructed on splinting techniques using a pillow for comfort and advised to take pain medication as needed for adequate control. Medications were reviewed and reconciled, with no abnormal bleeding or falls reported. The patient is temporarily staying with his brother for assistance, reports a decreased appetite, and had a bowel movement today; he was instructed to avoid straining, maintain hydration, and increase dietary fiber to prevent constipation. A PT evaluation was recommended for gait assessment. The patient was provided contact information for his PCP, Dr. Mohapatra, to schedule a follow-up appointment and has a surgical follow-up with Dr. Ghoreisha on 3/9/26 at Johns Hopkins Hospital; he was advised that insurance may require follow-up with a Kaiser Permanente provider.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 02/16/2026
 Order<o:p></o:p> Physician Face-to-Face Date: 02/10/2026
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management dx: Dissection of unspecified site of aorta
 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: <o:p></o:p> Physician:<span style="font-size: 10.5pt; background-image: initial; background-position: initial; background-size: initial; background-repeat: initial; background-attachment: initial; background-origin: initial; background-clip: initial;"> Mohapatra, Suryanarayan

SN Careplans

SN WK1: 1 (02/16/26-02/21/26) ,WK2: 2 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK5: 1 (03/15/26-03/21/26)

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: 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 ; Assess the patient's

SN Goals

PATIENT-STATED GOAL: to get back to normal

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
* 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 medicatio

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 02/16/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Suryanarayan Mohapatra
12201 Plum Orchard Dr
Silver Spring, MD 20904
PHONE: 7033597878 FAX: 13015723412 NPI: 1720487994

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 : 02/10/2026

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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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.

no wounds care orders
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal blood pressure, heartburn/indigestion, muscle weakness, limited strength, limited endurance, Pain Interference with Therapy activities, balance deficit, difficulty sleeping, Pain Interference with ADLs, Pain Effect on Sleep, loss of appetite, red/tender pressure points, #1 - Observable Surgical Wound - Anterior Midline - healed, #2 - Observable Surgical Wound - Anterior Right Thigh - healed

PROCEDURES: physician-ordered wound care: #2 - Observable Surgical Wound - Anterior Right Thigh - healed, physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Midline - healed, cough/deep breathing exercises, coordinate/arrange preparation of missing meals

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 medicatio, * 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 relaxatio, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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

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 relaxatio

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 RN	02/16/2026