Home Health Certification and Plan of Care

Order ID: 1150/17123

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
58267408	03/14/2026	From: 03/14/2026 To: 05/12/2026	3711	217058

6. Patient's Name and Address
Michael Komenda
300 Canterbury Road APt L,
Bel Air, MD 21014-
410-215-9761

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 03/10/1964 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z48.815	Encntr for surgical aftcr following surgery on the dgstv sys	03/14/26

13. ICD	Other Pertinent Diagnoses	Date
J44.9	Chronic obstructive pulmonary disease unspecified	03/14/26
J84.9	Interstitial pulmonary disease unspecified	03/14/26
C21.1	Malignant neoplasm of anal canal	03/14/26
D63.0	Anemia in neoplastic disease	03/14/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	03/14/26
K59.09	Other constipation	03/14/26
Z79.891	Long term (current) use of opiate analgesic	03/14/26
Z90.49	Acquired absence of other specified parts of digestive tract	03/14/26
Z87.891	Personal history of nicotine dependence	03/14/26

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

Albuterol - Albuterol inhale inhalant as necessary
Guaifenesin - Guaifenesin 600 mg by mouth as necessary
Pantoprazole - Pantoprazole Sodium 40mg by mouth once a day
Acetaminophen - Acetaminophen 650mg by mouth every 4 hours as needed for pain
Methadone - Methadone Hydrochloride 105mg by mouth once a day
Ondansetron - Ondansetron 4mg by mouth every 6 hours as needed for nausea
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg by mouth once a day
Gabapentin - Gabapentin 200mg by mouth once a day
Melatonin - Melatonin 3mg by mouth at bedtime
Bactrim - Sulfamethoxazole: Trimethoprim 400 mg;80 mg by mouth twice a day For 7 days

14. DME and Supplies:
ostomy supplies

15. Safety Measures:
smoke detectors , medication safety, fall precautions, ambulates with assistance, emergency phone # clearly displayed, supervision at all times, transfer with assist, standard precautions, bathroom safety, activity supervision

16. Nutrition:
regular

17. Allergies:
Chlorhexidine Gluconate

18.A. Functional Limitations
Bowel/Bladder Incontinence, , Endurance, Ambulation

18.B. Activities Permitted
Exercises Prescribed, 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
family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Encounter for surgical aftercare following surgery on the digestive system, 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 62-year-old male with a complex surgical and oncologic history, initially treated in March 2024 for diverticulitis complicated by a colovesical fistula requiring sigmoid colectomy and fistula takedown, followed by a postoperative course complicated by an anastomotic leak and pelvic abscess necessitating reoperation with colostomy creation. His recovery was prolonged due to a wound infection requiring wound VAC therapy, but he returned to baseline by August 2024. In February 2025, a planned colostomy reversal was aborted after discovery of an anal mass, with biopsy confirming invasive HPV-related squamous cell carcinoma; subsequent PET imaging showed localized disease without metastasis. He completed chemoradiation from March to May 2025, with follow-up studies in October and November 2025 showing no evidence of recurrence. The patient was seen today for an initial skilled nursing visit following hospitalization and abdominal surgery on March 4, 2026, for colostomy closure, low anterior resection, and creation of a diverting loop ileostomy. He currently has a midline abdominal incision with 33 staples, a left-sided ileostomy, and a right-sided Jackson-Pratt drain, and he successfully demonstrated proper management of both. He resides in a condominium with a live-in friend who serves as his caregiver, is full code, has no known drug allergies, and has all prescribed medications available at home; his surgical incision is left open to air, with staples scheduled for removal at a postoperative appointment.<o:p></o:p> <o:p> </o:p> Bottom of Form<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 03/14/2026
 Order<o:p></o:p> Physician Face-to-Face Date: 03/09/2026
 Clinical Condition Requiring Home Care per Certifying Physician: SN dx: Encounter for surgical aftercare following surgery on the digestive system
 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 -PT 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;"> Hernandez, Jenaro

SN Careplans

SN WK1: 1 (03/14/26-03/14/26) ,WK3: 1 (03/22/26-03/28/26) ,WK4: 1 (03/29/26-04/04/26) ,WK5: 1 (04/05/26-04/11/26) ,WK6: 1 (04/12/26-04/18/26)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if

SN Goals

PATIENT-STATED GOAL: Patient wants to be able to have his ileostomy reversal surgery so he no longer has to use a bag

GOALS
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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/14/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Jenaro Hernandez
1001 Pine Heights Ave
Abingdon, MD 21229
PHONE: 410-515-5440 FAX: NPI: 1386935724

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 : 03/09/2026

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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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 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, muscle weakness, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, M1630 - GI Ostomy, swell/redness surround. skin, bruising/discoloration

PROCEDURES: Jackson Pratt Drain Care: You need to empty the bulb as often as your health care provider tells you to. Follow the steps below: You will need: Measuring cup Record sheet Gauze or paper towel 1. Empty the bulb Wash your hands. Point the top of the bulb away from you and remove the stopper. Turn the bulb upside down over a measuring cup. Squeeze the fluid into the cup. 2. Clean and reconnect the bulb Clean the top of the bulb with clean gauze or paper towel, if needed. Squeeze the bulb in palm of hand to expel all the air. Keep the bulb squeezed and put the stopper back on the top. Note the amount of fluid in the cup and empty the cup as directed. Wash your hands. Record the fluid amount. , incentive spirometer: It is important to take deep breaths and cough to prevent pneumonia. Splint with a pillow (hug it against your abdomen) as needed when coughing or sneezing., incentive spirometer: y It is important to take deep breaths and cough to prevent pneumonia. Splint with a pillow (hug it against your abdomen) as needed when coughing or sneezing., train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: The skin glue should fall off on its own over the next few weeks You may shower with soap and water. Do not scrub the incisions. Pat the incisions dry. You may leave the wound open to air. Do not use any ointments unless instructed by your surgeon. Do not soak in a bath or hot tub (or swim in a pool) for 4 weeks or until after wounds are completely healed. Moderate bruising, swelling, and tenderness are normal. It can take up to 4-6 weeks for the swelling to go down. Apply an ice pack (20 minutes on and 20 minutes off) at the pain site., apply collection/fistula pouch, ostomy care & irrigation, 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, * ostomy management including how to clean stoma change ostomy pouch, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

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

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

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/14/2026