Home Health Certification and Plan of Care

Order ID: 1150/17748

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
36236059	04/02/2026	From: 04/02/2026 To: 05/31/2026	24445	217058

6. Patient's Name and Address

Raist Ferrell
3204 Burleith Avenue Apt C,
Baltimore, MD 21215-
443-881-0533

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 11/19/1966 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
D50.0	Iron deficiency anemia secondary to blood loss (chronic)	04/02/26

13. ICD	Other Pertinent Diagnoses	Date
F10.139	Alcohol abuse with withdrawal unspecified	04/02/26
E44.0	Moderate protein-calorie malnutrition	04/02/26
I10.	Essential (primary) hypertension	04/02/26
I70.0	Atherosclerosis of aorta	04/02/26
G62.9	Polyneuropathy unspecified	04/02/26
K31.89	Other diseases of stomach and duodenum	04/02/26
E83.42	Hypomagnesemia	04/02/26
D69.6	Thrombocytopenia unspecified	04/02/26
G31.9	Degenerative disease of nervous system unspecified	04/02/26
G40.909	Epilepsy unsp not intractable without status epilepticus	04/02/26
E78.5	Hyperlipidemia unspecified	04/02/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	04/02/26
Z79.82	Long term (current) use of aspirin	04/02/26
Z86.16	Personal history of COVID-19	04/02/26
Z91.81	History of falling	04/02/26

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

Magnesium Oxide - Simethicone 400 (240 Mg) MG / 1 Tablet by mouth once a day for 14 days.
MULTIVITAMIN 1 Tablet by mouth daily
THIAMINE 100 mg / 1 Tablet by mouth daily Commonly known as: VITAMIN B-1.
AMLODIPINE 10 mg / 1 Tablet by mouth daily Commonly known as: NORVASC
ASPIRIN 81 mg / 1 Tablet by mouth daily
CLOPIDOGREL 75 mg / 1 Tablet by mouth daily Commonly known as: PLAVIX
LEVETIRACETAM 500 mg / 1 Tablet by mouth 2 times daily Indications: Seizure disorder. For: Seizure disorder. Commonly known as: KEPPRA
NICOTINE 21 MG/24HR patch / Place 1 patch skin daily Commonly known as: NICODERM CQ
PANTOPRAZOLE Delayed Release 40 mg / 1 Tablet by mouth daily Indications: Gastroesophageal Reflux Disease For: Gastroesophageal Reflux Disease. Commonly known as: PROTONIX
QUETIAPINE FUMARATE 100 mg/tablet / Take 150 mg by mouth nightly Commonly known as: SEROquel

14. DME and Supplies:

rolling walker, walker, cane, 4 wheeled walker, crutches

15. Safety Measures:

walker precautions, medication safety, fall precautions, bleeding precautions, ambulates with device, ambulates with assistance, emergency phone # clearly displayed, transfer with assist, standard precautions, seizure precautions, hand rails, bathroom safety, activity supervision

16. Nutrition:

regular

17. Allergies:

atorvastatin

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: NA Patient nonresponsive, 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: 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

family/caregiver will be responsible for managing treatment

Homebound status: Due to diagnosis of Iron deficiency anemia secondary to blood loss (chronic), 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 59-year-old male with a significant medical history including severe alcohol use disorder, treated hepatitis C, atherosclerosis of the aorta, dyslipidemia, nicotine use, and a known seizure disorder. The patient was previously transferred from Sinai Hospital Emergency Department for direct admission for management of acute alcohol intoxication and anticipated alcohol withdrawal. Upon hospital presentation, the patient's ethanol level was significantly elevated at 304 mg/dL. Given his history of chronic alcohol use, he was identified as high risk for alcohol withdrawal. Although no seizures were documented during this episode, the patient's underlying seizure disorder placed him at increased risk for complications. Initial hospital evaluation also revealed metabolic abnormalities consistent with alcoholic ketoacidosis, including an elevated anion gap of 25 and a bicarbonate level of 13. Additional laboratory findings demonstrated anemia and thrombocytopenia, which were considered likely multifactorial in etiology, related to chronic alcohol use and possible nutritional deficiencies. The patient has since been discharged home and is initiating home health services for ongoing monitoring and support. He currently resides at home with his girlfriend, and his sister also assists with caregiving and support as needed. The patient ambulates with assistive devices and reports using both a walker and a crutch to maintain balance due to a prior right toe amputation that occurred several years ago. On assessment, the patient was noted to have two wounds present on the right foot. In addition, there is a growth present on the left foot for which the patient will follow up with podiatry for further evaluation and management. Continued monitoring of the right foot wounds and assessment of the left foot lesion are indicated to prevent complications and promote proper healing. The patient's code status is full code, and a Medical Orders for Life-Sustaining Treatment (MOLST) form is on file. The patient reports a medication allergy to Lipitor. Education was reinforced regarding the importance of medication adherence, wound care, fall prevention due to impaired balance and assistive device use, and the importance of attending scheduled follow-up appointments, particularly with podiatry and primary care providers. The plan of care includes skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-visits">visits</mh> for ongoing assessment of the patient's medical status, monitoring for complications related to alcohol withdrawal and chronic alcohol use, wound assessment and management of the right foot, reinforcement of safety precautions, and coordination of care with other healthcare providers as needed.
 Date of Order 04/02/2026 Orders Physician Face-to-Face Date: 03/30/2026 Clinical Condition Requiring Home Care per Certifying Physician: Dx: weakness, deconditioning, ambulatory dysfunction, gait instability, muscle weakness, fall risk Needs: Gait training, home safety evaluation, strengthening, ADL training, full prevention, functional mobility. due to Iron deficiency anemia secondary to blood loss (chronic) 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 <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/02/2026

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 : 03/30/2026

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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14px;">
 Physician Eseonu Ewoh, Nkechinyerem

SN Careplans

SN WK1: 1 (04/02/26-04/04/26) ,WK2: 1 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26) ,WK4: 1 (04/19/26-04/25/26) ,WK5: 1 (04/26/26-05/02/26) ,WK6: 1 (05/03/26-05/09/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 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 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:Refused

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M2020 - Oral Med Management, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, muscle weakness, limited strength, limited endurance, balance deficit, #1 - Blister - Other - right plantar ball of foot - , #2 - Blister - Posterior Right Ankle/Foot -

PROCEDURES: physician-ordered wound care: #1 - Blister - Other - right plantar ball of foot -: Keep wound clean dry and intact and covered with dry gauze., physician-ordered wound care: #2 - Blister - Posterior Right Ankle/Foot -: Keep wound clean dry and intact and covered with dry gauze., incentive spirometer, teach/coordinate/arrange medication packaging and/or administration

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 keep home safe for patient with dementia coping strategies for the caregiver*, 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 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, caregiver administers and/or packages medications appropriately

SN Goals

PATIENT-STATED GOAL: Patient states he wants to be able to go up and down the stairs safely again

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
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* 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/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* 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	04/02/2026