

Home Health Certification and Plan of Care					Order ID: 1150/18403	
1. Patient's HI claim No. 59286036		2. Start Of Care Date 05/01/2026		3. Certification Period From: 05/01/2026 To: 06/29/2026	4. Medical Record No. 25465	5. Provider No. 217058
6. Patient's Name and Address Tyrone Allen 3042 Arunah Ave, BALTIMORE, MD 21216- 229-315-0638				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 01/05/1989		9. Sex Male		10. Medications: Dose/Frequency/Route (N)ew (C)hanged METHOCARBAMOL 500 MG tablet by mouth 4 times daily for 14 days Commonly known as: ROBAXIN ONDANSETRON 4 MG tablet by mouth every 8 hours as needed for Nausea Commonly known as: ZOFTRAN ODT OXYCODONE 10 MG tablet by mouth every 4 hours as needed for Pain Commonly known as: ROXICODONE		
11. ICD Z48.815	Principal Diagnosis Encntr for surgical afctr following surgery on the dgstv sys		Date 05/01/26	15. Safety Measures: smoke detectors , emergency phone # clearly displayed, bathroom safety, medication safety, transfer with assist, standard precautions, fall precautions, activity supervision		
13. ICD E78.5	Other Pertinent Diagnoses Hyperlipidemia unspecified		Date 05/01/26			
F43.10	Post-traumatic stress disorder unspecified		Date 05/01/26			
G89.29	Other chronic pain		Date 05/01/26			
M54.9	Dorsalgia unspecified		Date 05/01/26			
E66.9	Obesity unspecified		Date 05/01/26			
Z68.33	Body mass index [BMI] 33.0-33.9 adult		Date 05/01/26			
Z87.891	Personal history of nicotine dependence		Date 05/01/26			
Z79.891	Long term (current) use of opiate analgesic		Date 05/01/26	17. Allergies: no known allergies		
14. DME and Supplies: wound care supplies						
16. Nutrition: low fiber				18.B. Activities Permitted Transfer bed/Chair, Up As Tolerated		
18.A. Functional Limitations None of the above				19. Mental & Psychosocial 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: 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: After undergoing Colon surgery, 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 <div>The patient is a 37-year-old male with a past medical history significant for chronic back pain, dyslipidemia, post-traumatic stress disorder, and a prior abdominal gunshot wound sustained in 2018 requiring colon surgery. The patient was recently hospitalized at Baltimore Washington Medical Center for a colostomy reversal and has since returned home for continued postoperative recovery and wound management under skilled nursing services. Upon skilled nursing admission assessment, the patient was alert and oriented, in stable condition, and exhibited no signs of acute distress. Vital signs were within normal limits. Physical assessment revealed a surgical wound located in the left lower quadrant of the abdomen. The wound bed appeared clean and healing appropriately, with no signs or symptoms of infection noted, including absence of erythema, edema, increased warmth, foul odor, or purulent drainage. The patient denied pain during the assessment and tolerated wound care procedures without discomfort or complication. Wound care was performed per physician orders, including cleansing the wound with wound cleanser, patting the area dry, applying Aquacel dressing to the wound cavity, and covering with an ABD pad secured with tape. The procedure was completed successfully with good patient tolerance. The patient remains ambulatory without the use of assistive devices and is able to move throughout the home independently. Family members are actively involved in the patient's care and assist with wound management and monitoring at home. Comprehensive education was provided to the patient and family regarding proper wound care techniques, infection prevention measures, and recognition of signs and symptoms requiring prompt medical attention, including increased pain, redness, swelling, drainage, fever, or changes in wound appearance. Medication management and adherence were reviewed in detail. Nutritional counseling was also provided, emphasizing the importance of adequate hydration and a high-protein diet to support wound healing and postoperative recovery. The patient and family verbalized understanding of all education and demonstrated receptiveness to the plan of care. Skilled nursing services will continue for ongoing wound assessment, postoperative monitoring, wound care management, and reinforcement of patient and caregiver education. The patient remains homebound due to recent surgical intervention, the need for continued skilled wound care, and the requirement for assistance and monitoring to safely leave the home during the recovery period.</div><div>
</div><div>Date of Order</div><div>Orders</div><div>Physician Face-to-Face Date: 04/28/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management due to Colon surgery</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>>1 - SOC - SN Notes: wound</div><div>
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</div><div>Physician</div><div>Hix, Kenetra</div></div>						
SN Careplans SN WK1: 5 (05/01/26-05/02/26) ,WK2: 5 (05/03/26-05/09/26) ,WK3: 4 (05/10/26-05/16/26) ,WK4: 4 (05/17/26-05/23/26) 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: 9. Other risk(s) not listed in 1- 8				SN Goals PATIENT-STATED GOAL: Patient stated he wants his wound to heal without complications GOALS patient/caregiver recalls * how to achieve wound healing including cleaning and dressing wound * position changes * skin care * diet modification * record wound measurements		
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 05/01/2026					25. Date HHA Received Signed POT	
24. Physician's Name and Address Kenetra Hix 3510 Brenbrook Dr Randallstown, O 21133 PHONE: 4107375000 FAX: 899290091 NPI: 1972917979				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 : 04/28/2026		
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. PAGE 1 of 2		

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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:No Advance Directive PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, meal preparation, M2102f - Patient Supervision, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, M1400 - Dyspnea, abdominal pain, limited range of motion, limited strength, limited endurance, Pain Interference with ADLs, B1000 - Vision Deficit, Pain Effect on Sleep, balance deficit, obesity, loss of appetite, #1 - Observable Surgical Wound - Other - Lower left abdominal quadrant - PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - Lower left abdominal quadrant -, cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: Cleanse wound with wound cleaner and pat dry. Pack cavity with Aquacel ribbon and cover with 4x4 gauze or ABD pad. Change every other day o4 as needed for soiled dressing. 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence	* 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 patient/caregiver recalls * how to keep home safe for patient with vision loss including eliminating hazards * enhancing lighting * using mechanical aids patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule patient's transportation needs are met patient is adequately supervised meal preparation is available to patient for all meals caregiver performs medical/rehabilitation treatments with adequate competence
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Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/01/2026