Home Health Certification and Plan of Care

Order ID: 1150/18490

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
39353602	05/06/2026	From: 05/06/2026 To: 07/04/2026	25641	217058

6. Patient's Name and Address

John Lavin
2100 Morgan St,
EDGEWOOD, MD 21040-
443-617-2662

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 01/16/1968 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.81	Encounter for orthopedic aftercare following surgical amp	05/06/26

13. ICD	Other Pertinent Diagnoses	Date
E11.69	Type 2 diabetes mellitus with other specified complication	05/06/26
M86.9	Osteomyelitis unspecified	05/06/26
L02.611	Cutaneous abscess of right foot	05/06/26
I11.0	Hypertensive heart disease with heart failure	05/06/26
I50.21	Acute systolic (congestive) heart failure	05/06/26
I48.0	Paroxysmal atrial fibrillation	05/06/26
I71.21	Aneurysm of the ascending aorta without rupture	05/06/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	05/06/26
I87.303	Chronic venous hypertension w/o comp of bilateral low extrm	05/06/26
I42.0	Dilated cardiomyopathy	05/06/26
F41.9	Anxiety disorder unspecified	05/06/26
F32.A	Depression unspecified	05/06/26
E78.5	Hyperlipidemia unspecified	05/06/26
M17.11	Unilateral primary osteoarthritis right knee	05/06/26
M47.812	Spondylosis w/o myelopathy or radiculopathy cervical region	05/06/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/06/26
E66.9	Obesity unspecified	05/06/26
Z68.34	Body mass index [BMI] 34.0-34.9 adult	05/06/26
Z89.421	Acquired absence of other right toe(s)	05/06/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	05/06/26
Z79.01	Long term (current) use of anticoagulants	05/06/26
Z86.0100	Personal history of colonic polyps	05/06/26

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

ACETAMINOPHEN 325 mg/tablet / Take 2 tablets by mouth every 6 hours as needed for MILD Pain (or if patient requests it for moderate or severe pain). Commonly known as: TYLENOL
METRONIDAZOLE 500 mg / 1 Tablet by mouth 2 times daily for 14 days Commonly known as: FLAGYL
OXYCODONE Immediate Release 5 MG / 1 Tablet by mouth every 6 hours as needed for MODERATE Pain (or if patient requests it for severe pain) or Breakthrough Pain for up to 12 doses. Commonly known as: ROXICODONE
sulfamethoxazole-trimethoprim 800-160 mg / 1 Tablet by mouth 2 times daily for 14 days Commonly known as: BACTRIM DS
ATORVASTATIN 40 mg / 1 Tablet by mouth once a day Commonly known as: LIPITOR
DABIGATRAN ETEXILATE 150 mg / 1 Capsule by mouth every 12 hours Commonly known as: PRADAXA
DULOXETINE HYDROCHLORIDE Delayed Release 30 mg / 1 Capsule by mouth twice a day Commonly known as: CYMBALTA
Jardiance - Empagliflozin 10 mg / 1 Tablet by mouth every evening
METFORMIN 1000 mg / 1 Tablet by mouth twice a day with meals. Commonly known as: GLUCOPHAGE
Metoprolol Succinate - Metoprolol Succinate Extended Release 24 Hour 50 mg / 1 Tablet by mouth once a day Commonly known as: TOPROL XL
PANTOPRAZOLE Delayed Release 40 mg / 1 Tablet by mouth once a day Commonly known as: PROTONIX

14. DME and Supplies:

wound care supplies

15. Safety Measures:

medication safety, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, transfer with assist, emergency phone # clearly displayed, ambulates with assistance, standard precautions, bathroom safety, anticoagulant precautions, activity supervision, partial right foot weight bearing

16. Nutrition:

high protein, diabetic

17. Allergies:

penicillin g

18.A. Functional Limitations

Ambulation, Amputation, Endurance

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: Yes

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 Right second toe amputation with incision and drainage, 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: Patient is a 58-year-old male admitted for right second toe osteomyelitis and right foot abscess without evidence of systemic inflammatory response syndrome. Lower extremity venous Doppler studies were negative for deep vein thrombosis, and arterial Doppler studies were within normal limits. Patient is status post right second toe amputation with incision and drainage performed by podiatry. Surgical dressing remains clean, dry, and intact. Per podiatry recommendations, patient is restricted to heel weight-bearing only for transfers and pivoting activities. Wound care orders include dressing and packing changes three times weekly utilizing 1/4 to 1/2 inch iodoform packing followed by dry sterile dressing application. Patient continues to be monitored closely for wound healing, drainage, signs of infection, and pain control. Infectious Disease consultation completed by Dr. Eilertson with transition from IV antibiotic therapy to oral antibiotics including Levofloxacin 750 mg daily and Metronidazole 500 mg twice daily for a planned two-week course. Intraoperative culture results remain pending at this time. Patient is being monitored for tolerance and response to antibiotic therapy, including adverse effects and progression or resolution of infection symptoms. Past medical history is significant for nonischemic cardiomyopathy with reduced ejection fraction of 20-25%, ascending thoracic aortic aneurysm, paroxysmal atrial fibrillation, hypertension, type 2 diabetes mellitus, and hyperlipidemia. Patient is currently euvolemic with no acute signs or symptoms of

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/06/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Nkemdilim Adimorah
5401 Old Court Rd
Randallstown, MD 21133
PHONE: 4436350583 FAX: NPI: 1841941242

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 : 05/05/2026

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.

Home Health Certification and Plan of Care

Order ID: 1150/18490

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
39353602	05/06/2026	From: 05/06/2026 To: 07/04/2026	25641	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
John Lavin 2100 Morgan St, EDGEWOOD, MD 21040- 443-617-2662	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

congestive heart failure noted during assessment. Recent echocardiogram demonstrated a dilated aortic root and ascending aortic aneurysm measuring 4.7 cm. Patient denied chest pain or acute cardiovascular symptoms. Patient continues prescribed cardiac regimen including Toprol-XL 50 mg daily, Pradaxa 150 mg twice daily for atrial fibrillation, and Lipitor for hyperlipidemia management. Outpatient cardiology and cardiothoracic surgery follow-up have been recommended for ongoing monitoring of cardiomyopathy and ascending aortic aneurysm. Type 2 diabetes mellitus appears well controlled with most recent hemoglobin A1c of 6.5. Blood glucose was managed with sliding scale insulin during hospitalization. Patient remained alert and oriented with vital signs stable and no acute distress observed during assessment. Continued skilled nursing services are indicated for wound assessment and care, monitoring for infection, medication management and education, diabetic management, cardiovascular monitoring, reinforcement of weight-bearing precautions, pain assessment, and ongoing evaluation of response to oral antibiotic therapy to reduce risk of complications and rehospitalization.
 Date of Order 05/06/2026 Orders Physician Face-to-Face Date: 05/05/2026 Clinical Condition Requiring Home Care per Certifying Physician: foot osteomyelitis, abscess, deconditioning due to Right second toe amputation with incision and drainage 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
 Physician Adimorah, Nkemdilim

SN Careplans

SN WK1: 1 (05/06/26-05/09/26) ,WK2: 2 (05/10/26-05/16/26) ,WK3: 2 (05/17/26-05/23/26) ,WK4: 1 (05/24/26-05/30/26) ,WK5: 1 (05/31/26-06/06/26) ,WK6: 1 (06/07/26-06/13/26) ,WK7: 1 (06/14/26-06/20/26)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 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; 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:Received

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, dependent edema, M1400 - Dyspnea, M1033 - Exhaustion, muscle weakness, limited endurance, limited strength, swelling of affected area, Pain Effect on Sleep, Pain Interference with ADLs, bleeding/discharge at site, #1 - Observable Surgical Wound - Other - right second tow amputation - Right second toe amputation. Incision held together with sutures., #2 - Observable Surgical Wound - Other - plantar aspect of the 1st/2nd proximal phalanges - , red/tender pressure points, swell/redness surround. skin

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - right second tow amputation - Right second toe amputation. Incision held together with sutures.: Cover with dry gauze and keep sutures clean dry and intact., physician-ordered wound care: #2 - Observable Surgical Wound - Other - plantar aspect of the 1st/2nd proximal phalanges -: Perform wound care/dressing changes 3 times weekly as ordered. Remove old dressing and packing carefully. Cleanse wound with normal saline/wound cleanser per protocol. Gently pack wound with 1/4-inch or 1/2-inch iodoform packing strip as ordered, avoiding overpacking. Cover with dry sterile gauze dressing and secure appropriately. Monitor wound for drainage, odor, redness, swelling, increased pain, or other signs/symptoms of infection. Patient may transfer/pivot on heel only per podiatry recommendations. Notify provider of fever, worsening drainage, increased erythema, or wound deterioration., cough/deep breathing exercises, 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 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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: I want my wounds to heal so I can return back to work

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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* 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 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
* 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	05/06/2026