

Home Health Certification and Plan of Care				Order ID: 1150/18532	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
39353602		05/06/2026		From: 05/06/2026 To: 07/04/2026	
				4. Medical Record No.	
				25641	
				5. Provider No.	
				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		
8. DOB			9. Sex		
01/16/1968			Male		
11. ICD			Date		
Z47.81			05/06/26		
Principal Diagnosis			Encounter for orthopedic aftercare following surgical amp		
13. ICD			Date		
E11.69			05/06/26		
Other Pertinent Diagnoses			Type 2 diabetes mellitus with other specified complication		
M86.9			05/06/26		
L02.611			05/06/26		
Osteomyelitis unspecified			Cutaneous abscess of right foot		
I11.0			05/06/26		
I50.21			05/06/26		
I48.0			05/06/26		
I71.21			05/06/26		
E11.40			05/06/26		
I87.303			05/06/26		
Hypertensive heart disease with heart failure			Acute systolic (congestive) heart failure		
I42.0			05/06/26		
F41.9			05/06/26		
F32.A			05/06/26		
E78.5			05/06/26		
M17.11			05/06/26		
M47.812			05/06/26		
Dilated cardiomyopathy			Anxiety disorder unspecified		
K21.9			05/06/26		
E66.9			05/06/26		
Z68.34			05/06/26		
Z89.421			05/06/26		
Z79.84			05/06/26		
Z79.01			05/06/26		
Z86.0100			05/06/26		
Depression unspecified			Hyperlipidemia unspecified		
Unilateral primary osteoarthritis right knee			Spondylolysis w/o myelopathy or radiculopathy cervical region		
Gastro-esophageal reflux disease without esophagitis			Obesity unspecified		
Body mass index [BMI] 34.0-34.9 adult			Acquired absence of other right toe(s)		
Long term (current) use of oral hypoglycemic drugs			Long term (current) use of anticoagulants		
Personal history of colonic polyps					
14. DME and Supplies:			15. Safety Measures:		
wound care supplies			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:			17. Allergies:		
high protein, diabetic			penicillin g		
18.A. Functional Limitations			18.B. Activities Permitted		
Ambulation, Amputation, Endurance			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:			22.B.Discharge Plans		
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.			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:			<div>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 congestive heart failure noted during		
23. Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT		
Electronically Signed by Messick, Charles RN on 05/06/2026					
24. Physician's Name and Address			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.		
Sonia Sharma 3400 Box Hill Center Dr Abingdon, 0 21009 PHONE: 410-515-5440 FAX: NPI: 1336595925			F2F date : 05/05/2026		
27. Attending Physician's Signature and Date Signed			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.		
: Date of physician last face-to-face			PAGE 1 of 2		

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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.

Face-to-Face Date: 05/05/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: foot osteomyelitis, abscess, deconditioning due to Right second toe amputation with incision and drainage</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: soc</div><div>
</div><div>
</div><div>Physician</div><div>
</div>Sharma, Sonia</div>

SN Careplans SN WK1: 2 (05/06/26-05/09/26) 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: 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
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/06/2026