Home Health Certification and Plan of Care

Order ID: 1150/18627

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
811290376	05/12/2026	From: 05/12/2026 To: 07/10/2026	25718	217058

6. Patient's Name and Address
Zelda Purvis
2854 Kentucky Avenue,
BALTIMORE, MD 21213-
410-488-5329

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 08/27/1962 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
K70.30	Alcoholic cirrhosis of liver without ascites	05/12/26

13. ICD	Other Pertinent Diagnoses	Date
F10.10	Alcohol abuse uncomplicated	05/12/26
K76.82	Hepatic encephalopathy	05/12/26
G89.4	Chronic pain syndrome	05/12/26
I73.9	Peripheral vascular disease unspecified	05/12/26
D69.6	Thrombocytopenia unspecified	05/12/26
M87.9	Osteonecrosis unspecified	05/12/26
I70.203	Unsp athscl native arteries of extremities bilateral legs	05/12/26
D64.9	Anemia unspecified	05/12/26
F32.A	Depression unspecified	05/12/26
R63.4	Abnormal weight loss	05/12/26
R91.1	Solitary pulmonary nodule	05/12/26
F17.210	Nicotine dependence cigarettes uncomplicated	05/12/26

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

Acetaminophen - Acetaminophen Extended Release 650 mg tablet by mouth every 8 hours for PAIN MANAGEMENT GIVE BY MOUTH DO NOT EXCEED 3 GRAMS OF APAP/ 24 HOURS FROM ALL SOURCES 2 TABS = 1000MG
Duloxetine Hydrochloride - Duloxetine Hydrochloride Delayed Release 30 mg / 1 Capsule by mouth every 12 hours for Depression
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) mg / 1 Tablet by mouth once a day for supplementation
FOLIC ACID 1 mg / 1 Tablet by mouth once a day for Supplement
GABAPENTIN 600 mg / 1 Tablet by mouth three times a day for Neuropathy
Lactulose - Lactulose Oral Solution 10 GM/15ML / Give 15 ml by mouth twice a day for liver Cirrhosis
Melatonin - Melatonin 3 mg / 1 Tablet by mouth at bedtime for Sleep Aide
BUPRENORPHINE HYDROCHLORIDE Patch 10 MCG/HR / Apply 1 patch transdermal once a day every 7 days for Chronic pain Ensure old patch is removed

14. DME and Supplies:
wheelchair, walker, hoyer lift, wound care supplies, hospital bed

15. Safety Measures:
smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with device, ambulates with assistance, medication safety, walker precautions, transfer with assist, wheelchair precautions, standard precautions, no bp left arm, fall precautions, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
diclofenac nickel

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

18.B. Activities Permitted
Up As Tolerated, Walker, Exercises Prescribed, Wheelchair, Transfer bed/Chair

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: 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 Alcoholic cirrhosis of liver without ascites, 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: Home health skilled nursing admission was completed for a 63-year-old female recently discharged from a rehabilitation facility to home with home health services. Past medical history is significant for anemia, cirrhosis of the liver, gastroesophageal reflux disease (GERD), depression, osteonecrosis, and alcohol abuse. The patient was alert and oriented x3 during the visit and is currently residing with her sister, who serves as the primary caregiver and assists with daily care needs. The patient demonstrates generalized weakness, limited endurance, and impaired mobility, requiring use of a walker with assistance for short-distance ambulation and a wheelchair for mobility support. The patient also requires extensive assistance with activities of daily living (ADLs) and ongoing supervision to maintain safety within the home environment. Comprehensive assessment was completed, revealing an ulcer to the right lateral foot and a stage 2 pressure injury to the posterior upper thigh. At the time of the visit, no formal wound care orders were available. The patient and caregiver reported current wound management consists of keeping the affected areas clean and covered with gauze dressings. The physician will be notified to obtain wound care orders and additional treatment recommendations for ongoing wound management. Skin integrity and pressure injury prevention were discussed extensively with the patient and caregiver. Skilled nursing education was provided regarding wound care techniques, infection prevention, pressure relief measures, frequent repositioning, maintenance of skin integrity, medication management, fall prevention, and general safety precautions. The patient and caregiver were also instructed on monitoring for and promptly reporting signs and symptoms of infection or wound complications, including redness, drainage, swelling, foul odor, fever, or increased pain, as well as when to notify the home health agency or physician of worsening symptoms or changes in condition. Both the patient and caregiver verbalized understanding of all education provided. The patient remains homebound due to impaired mobility, weakness, decreased endurance, need for assistive devices, and requirement for caregiver assistance and supervision. Skilled nursing services are medically necessary for ongoing comprehensive assessment, wound monitoring and management, medication education, disease process management, skin integrity monitoring, and reinforcement of safety and infection prevention measures to reduce risk of further decline and rehospitalization.
 Date of Order 05/12/2026 Orders Physician Face-to-Face Date: 05/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Alcoholic cirrhosis of liver without ascites 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 Wilson, Marc

SN Careplans	SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/12/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Marc Wilson
815 E Pratt St
Baltimore, MD 21202
PHONE: 410-637-5700 FAX: 1-410-637-5701 NPI: 1275565251

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 : 05/06/2026

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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SN WK1: 1 (05/12/26-05/16/26) ,WK2: 1 (05/17/26-05/23/26) ,WK3: 1 (05/24/26-05/30/26) ,WK4: 1 (05/31/26-06/06/26) ,WK5: 1 (06/07/26-06/13/26) ,WK6: 1 (06/14/26-06/20/26) ,WK7: 1 (06/21/26-06/27/26) ,WK8: 1 (06/28/26-07/04/26)

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 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, Home Safety, A1250 - Lack of Necessary Transportation, M1400 - Dyspnea, M1610 - Urinary Incontinence, limited strength, limited endurance, muscle weakness, limited range of motion, Pain Interference with ADLs, B1000 - Vision Deficit, Pain Effect on Sleep, balance deficit, obesity, #1 - Open Wound - Other - Right lateral foot - , #2 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Other - Left posterior upper thigh - , open sores/lesions

PROCEDURES: physician-ordered wound care: #2 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Other - Left posterior upper thigh -: Cleanse wound with wound cleaner and pat dry apply zinc paste and cover with dry dressing every other day and as-needed for soiled dressing, physician-ordered wound care: #1 - Open Wound - Other - Right lateral foot -: Cleanse wound with wound cleaner and pat dry, apply alginate dressing and cover with dry dressing 3 times week and as needed for soiled dressing., physician-ordered wound care, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired

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, * urinary incontinence management including bladder training Kegel exercises skin care, 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, insects/rodents not present in the patient's living environment, patient is adequately supervised, meal preparation is available to patient for all meals,

PATIENT-STATED GOAL: Start walking without help

GOALS
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
* 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 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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

insects/rodents not present in the patient's living environment

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/12/2026

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caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 3 of 3
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