Home Health Certification and Plan of Care

Order ID: 1150/19071

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
931057785	05/28/2026	From: 05/28/2026 To: 07/26/2026	26247	217058

6. Patient's Name and Address

Richard Ogin
1321 Malbay Drive,
LUTHERVILLE TIMONIUM, MD 21093-
410-207-4953

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 07/12/1949 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z48.815	Encntr for surgical aftcr following surgery on the dgstv sys	05/28/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	05/28/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	05/28/26
E78.5	Hyperlipidemia unspecified	05/28/26
G47.00	Insomnia unspecified	05/28/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/28/26
Z90.49	Acquired absence of other specified parts of digestive tract	05/28/26
Z79.01	Long term (current) use of anticoagulants	05/28/26
Z79.82	Long term (current) use of aspirin	05/28/26
Z95.5	Presence of coronary angioplasty implant and graft	05/28/26

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

magnesium glycinate 1 tab by mouth once a day supplement
Loratadine - Loratadine 10 mg 10mg; 1 tab by mouth once a day allergies
Vitamin D (Cholecalciferol) 1250 MCG; 1 TAB by mouth once a week SUPPLEMENT
Azelastine Hydrochloride - Azelastine Hydrochloride 0.05 perc 0.15 1 SPRAY nasal twice a day ALLERGIES
LIPITOR eq 40 mg base 40 mg; 1 tab Oral nightly cholesterol
TENORMIN 25 mg 25 mg; 1 tab Oral 1 time daily blood pressure
SUPER B COMPLEX 1 tab Oral once a day supplement
DYAZIDE 37.5-25 mg / 1 Capsule Oral 1 time daily every morning blood pressure
ASPIRIN 81 MG tablet delayed release Oral 1 time daily PROPHYLACTIC

14. DME and Supplies:

wound care supplies

15. Safety Measures:

standard precautions, fall precautions, bleeding precautions, medication safety, infectious material management

16. Nutrition:

low cholesterol, low sodium, low fiber

17. Allergies:

azithromycin penicillin tessalon bee venom

18.A. Functional Limitations

Endurance

18.B. Activities Permitted

Up As Tolerated, Exercises Prescribed

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: No

20. Prognosis: fair

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

patient will be responsible for managing treatment

Homebound status:

Due to diagnosis of Encounter for surgical aftercare following surgery on the digestive system, 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 was recently admitted with complaints of lower abdominal pain and nausea and was diagnosed with perforated appendicitis with abscess, coronary artery disease (CAD), and dyspnea on exertion (DOE). The patient is status post percutaneous cholecystostomy and laparoscopic appendectomy converted to open appendectomy/cecectomy with cholecystostomy tube placement on 5/20. Past medical history includes hypertension, hyperlipidemia, and insomnia. The patient is alert and oriented 3, denies pain and shortness of breath, and demonstrates clear lung sounds, good appetite, and bowel movement reported today. The patient reports hemorrhoids and decreased endurance, with trace to +1 bilateral lower extremity edema noted. A midline abdominal incision with staples measures 19.0 cm in length and contains two open areas: the proximal wound measures 3.0 2.0 1.7 cm, and the distal wound measures 2.5 1.2 3.0 cm. Orders are in place for normal saline wet-to-dry dressing changes. A right upper quadrant biliary drain is present with scant drainage noted. Reddened areas to the buttocks and gluteal fold are open to air. The spouse has been instructed on wound care and performs dressing changes when skilled nursing is unavailable. Skilled nursing services are ordered, along with PT evaluation and treatment. The patient and spouse were receptive to all education and instructions provided.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 05/28/2026
 Order<o:p></o:p> Physician Face-to-Face Date: 05/23/2026
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat dx: Encounter for surgical aftercare following surgery on the digestive system
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
 1 - SOC - SN Notes:<o:p></o:p> Physician: Obioha, Nkiruka

SN Careplans

SN WK1: 1 (05/28/26-05/30/26) ,WK2: 1 (05/31/26-06/06/26) ,WK3: 2 (06/07/26-06/13/26) ,WK4: 1 (06/14/26-06/20/26) ,WK5: 1 (06/21/26-06/27/26) ,WK6: 1 (06/28/26-07/04/26) ,WK7: 1 (07/05/26-07/11/26) ,WK8: 1 (07/12/26-07/18/26)

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: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion,

SN Goals

PATIENT-STATED GOAL: TO GET MY STRENGTH BACK

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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/28/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Nkiruka Obioha
2391 Greenspring Drive
Timonium, MD 21093
PHONE: 4108473000 FAX: 8554160980 NPI: 1073650024

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 : 05/23/2026

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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9. Other risk(s) not listed in 1- 8

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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, dependent edema, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, limited endurance, balance deficit, Pain Interference with ADLs, red/tender pressure points, #1 - Observable Surgical Wound - Other - PROXIMAL ABDOMINAL WOUND - , #2 - Observable Surgical Wound - Other - DISTAL ABDOMINAL WOUND -

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - PROXIMAL ABDOMINAL WOUND -, physician-ordered wound care: #2 - Observable Surgical Wound - Other - DISTAL ABDOMINAL WOUND -, RUQ GALLBLADDER DRAIN: EMPTY DAILY AND RECORD OUTPUT AMOUNT, BUTTOCK AND GLUTEAL FOLD REDNESS: CLEAN WITH SOAP AND WATER . KEEP AREA OPEN TO AREA., cough/deep breathing exercises, incentive spirometer

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, * 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, meal preparation is available to patient for all meals

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

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/28/2026