Home Health Certification and Plan of Care

Order ID: 1150/19170

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
38159770	05/31/2026	From: 05/31/2026 To: 07/29/2026	26376	217058

6. Patient's Name and Address

Karen Kaczynski
1712 Woodland Dr,
DUNDALK, MD 21222-
410-285-7106

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 01/05/1954 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z48.3	Aftercare following surgery for neoplasm	05/31/26

13. ICD	Other Pertinent Diagnoses	Date
C67.9	Malignant neoplasm of bladder unspecified	05/31/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	05/31/26
N18.31	Chronic kidney disease stage 3a	05/31/26
I83.93	Asymptomatic varicose veins of bilateral lower extremities	05/31/26
G62.9	Polyneuropathy unspecified	05/31/26
E78.5	Hyperlipidemia unspecified	05/31/26
N20.0	Calculus of kidney	05/31/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/31/26
R73.03	Prediabetes	05/31/26
E66.9	Obesity unspecified	05/31/26
Z68.33	Body mass index [BMI] 33.0-33.9 adult	05/31/26
Z93.6	Other artificial openings of urinary tract status	05/31/26
Z89.421	Acquired absence of other right toe(s)	05/31/26
Z90.710	Acquired absence of both cervix and uterus	05/31/26
Z90.722	Acquired absence of ovaries bilateral	05/31/26
Z87.891	Personal history of nicotine dependence	05/31/26

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

MULTIVITAMIN 1 tablet by mouth daily
VITRON-C PO by mouth Every other day
ATORVASTATIN 40 MG tablet by mouth nightly Commonly known as: LIPITOR
AMOXICILLIN 500 MG capsule by mouth 2 times daily Commonly known as: AMOXIL
Metoprolol Succinate - Metoprolol Succinate Extended Release 24 Hour 50 MG tablet by mouth every morning Commonly known as: TOPROL XL
Potassium Citrate - Potassium Citrate Extended Release 10 MEQ (1080 MG) tablet by mouth three times a day with meals. Commonly known as: UROCIT-K

14. DME and Supplies:

ostomy supplies, rolling walker, hand held shower, bath bench, wound care supplies, 4 wheeled walker

15. Safety Measures:

standard precautions, no bending, hand rails, fall precautions, ambulates with device, walker precautions, smoke detectors , medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, bathroom safety, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

alpha lipoic acid

18.A. Functional Limitations

Bowel/Bladder Incontinence, Endurance, Ambulation

18.B. Activities Permitted

Walker, 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: 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 Radical cystectomy with lymph node dissection, ileal conduit urinary diversion, and hysterectomy, 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 72-year-old female with a primary diagnosis of metastatic bladder cancer status post radical cystectomy with lymph node dissection, ileal conduit urinary diversion, and hysterectomy. The patient was recently hospitalized for surgical management of metastatic bladder cancer. During the operative procedure, estimated blood loss was approximately 700 mL. Postoperatively, the patient experienced an uncomplicated recovery and received extensive education from the wound and ostomy nurse regarding care and management of her newly created ileal conduit urostomy. She progressed appropriately throughout her hospitalization, demonstrating the ability to ambulate independently and tolerate her prescribed diet. The Jackson-Pratt (JP) drain was removed by the Urology team prior to discharge, and all necessary urostomy supplies were delivered before discharge home. The hospital course was complicated by an episode of acute kidney injury, which resolved prior to discharge. Hypertension was managed with resumption of prescribed beta-blocker therapy, resulting in stabilization of blood pressure prior to discharge. The patient was discharged home in stable condition but remains homebound secondary to recent major abdominal surgery, postoperative weakness, decreased endurance, and the need for ongoing assistance and education related to wound healing and urostomy management. Skilled nursing services are medically necessary to provide comprehensive postoperative assessment and monitoring, including evaluation of cardiopulmonary status, vital signs, overall recovery progress, and identification of any signs or symptoms of postoperative complications. Skilled nursing will assess surgical incisions for signs of infection, dehiscence, delayed healing, drainage, or other abnormalities and will monitor the urostomy stoma for appropriate color, appearance, function, and output. Ongoing nursing interventions will include reinforcement of urostomy care techniques, appliance management, skin integrity protection, monitoring of urinary output, and assessment of hydration status. The patient will be monitored closely for signs and symptoms of infection, bleeding, electrolyte imbalance, urinary complications, recurrence of acute kidney injury, or other postoperative concerns. Medication reconciliation will be completed with ongoing education provided regarding prescribed medications, including proper administration, potential side effects, and adherence to antihypertensive therapy. Blood pressure monitoring and evaluation of compliance with medication regimens will be performed routinely. Patient and caregiver education will focus on disease process management, recognition of complications requiring medical attention, infection prevention measures, hydration importance, ostomy self-care, medication management, safety precautions, and energy conservation techniques to support recovery and reduce the risk of rehospitalization. Skilled nursing will also coordinate care and communicate changes in condition with the patient's urology, oncology, and primary care providers as indicated. The plan of care includes ongoing skilled nursing visits for postoperative assessment, ostomy management and education, medication management, monitoring for complications, and reinforcement of self-care strategies to promote safe

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/31/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Barbara Sanico
4920 Campbell Blvd
Baltimore, MD 21236
PHONE: 410-933-7600 FAX: NPI: 1164454716

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 : 05/18/2026

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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recovery, maximize independence, and support optimal health outcomes within the home environment.
 Date of Order 05/31/2026 Orders Physician Face-to-Face Date: 05/18/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management due to Radical cystectomy with lymph node dissection, ileal conduit urinary diversion, and hysterectomy 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 Sanico, Barbara

SN Careplans

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

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: M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, limited strength, limited endurance, daytime fatigue, balance deficit, Pain Effect on Sleep, Pain Interference with ADLs, obesity, loss of appetite, swell/redness surround. skin, #2 - Observable Surgical Wound - Other - abdominal upper midline - , #1 - Open Wound - Other - Midline abdominal -

PROCEDURES: physician-ordered wound care: #1 - Open Wound - Other - Midline abdominal -: Cleans abdominal incision with acetic acid and pat dry. Apply Santyl to the wound bed and cover with boarder foam dressing. Change every two-three days., physician-ordered wound care: #2 - Observable Surgical Wound - Other - abdominal upper midline -: Cleans abdominal incision with acetic acid and pat dry. Apply Santyl to the wound bed and cover with boarder foam dressing. Change every two-three days., cough/deep breathing exercises, incentive spirometer, monitor intake & output, 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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: Patient wants to learn how to be independent with her urostomy changes

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
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/31/2026