Home Health Certification and Plan of Care

Order ID: 1150/19536

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
AA00019540	06/08/2026	From: 06/08/2026 To: 08/06/2026	26642	217058

6. Patient's Name and Address
Louise Minor
2024 N SMALLWOOD ST,
BALTIMORE, MD 21216
410-736-3161

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 10/23/1959 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
K86.0	Alcohol-induced chronic pancreatitis	06/08/26

13. ICD	Other Pertinent Diagnoses	Date
F10.90	Alcohol use unspecified uncomplicated	06/08/26
N17.9	Acute kidney failure unspecified	06/08/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	06/08/26
N18.30	Chronic kidney disease stage 3 unspecified	06/08/26
D63.1	Anemia in chronic kidney disease	06/08/26
M10.9	Gout unspecified	06/08/26
E78.5	Hyperlipidemia unspecified	06/08/26
M48.061	Spinal stenosis lumbar region without neurogenic claud	06/08/26
M54.16	Radiculopathy lumbar region	06/08/26
E43.	Unspecified severe protein-calorie malnutrition	06/08/26
M43.16	Spondylolisthesis lumbar region	06/08/26
H26.9	Unspecified cataract	06/08/26
M19.90	Unspecified osteoarthritis unspecified site	06/08/26
D50.9	Iron deficiency anemia unspecified	06/08/26
N25.81	Secondary hyperparathyroidism of renal origin	06/08/26
Z79.891	Long term (current) use of opiate analgesic	06/08/26

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

TYLENOL 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) or Fever (temp in PRN comment) (for fever > 38.0 and notify physician).
NORVASC 10 mg / 1 Tablet by mouth daily.
Metoprolol Tartrate - Metoprolol Tartrate 100 mg / 1 Tablet by mouth 2 times daily.
THERAGRAN 1 tablet by mouth daily.
ROXICODONE Immediate Release 5 MG / 1 Tablet by mouth as necessary EVERY 6 HOURS
Folic Acid - Folic Acid 1 mg 1mg by mouth once a day Supplemental
MIRALAX 17 g packet / Take 1 packet by mouth as necessary Stir and dissolve 1 packet in any 4-8 ounces of non-carbonated beverage.
Protonix - Pantoprazole Sodium eq 40 mg base 40mg by mouth once a day GERD
Tizanidine Hydrochloride - Tizanidine Hydrochloride eq 4 mg base 4mg by mouth twice a day
Creon - Pancrelipase (Amylase:Lipase:Protease) 120,000usp units;24,000usp units;76,000usp units 120,000usp units;24,000usp units;76,000usp units (capsule, delayed release; oral) by mouth once a day
Colchicine - Colchicine 0.6mg by mouth twice a day
Atorvastatin - Atorvastatin Calcium 20mg by mouth once a day
ALBUTEROL 108 (90 BASE) mcg/act IN aerosol solution / Take 1 puff inhalation by inhalation as instructed.
Nicoderm Cq - Nicotine 14 MG/24HR patch / Place 1 patch transdermal in the morning

14. DME and Supplies:
cane, walker

15. Safety Measures:
bathroom safety, walker precautions, , supervision at all times, standard precautions, fall precautions, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:
low cholesterol, low sodium,

17. Allergies:
allopurinol

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Cane, 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: 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
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Alcohol-induced chronic pancreatitis, 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 is a 69-year-old female admitted to home health services following a recent hospitalization for acute alcohol-induced pancreatitis and acute kidney injury. All admission consents were reviewed and signed by the patient. Her past medical history is significant for alcohol-induced pancreatitis, spondylosis, hypertension, hypertensive kidney disease, hyperlipidemia, malnutrition, and gastroesophageal reflux disease (GERD). Due to her recent hospitalization, ongoing medical needs, medication management requirements, and impaired mobility, the patient is considered homebound. Leaving the home requires considerable and taxing effort as she ambulates with a walker and cane and requires one-person assistance for safety and fall prevention. Upon assessment, the patient was alert and oriented to person, place, and time, with occasional fluctuations requiring minimal cueing, and was able to participate appropriately in the visit. She reported no pain or acute distress. The patient is recovering from her recent episode of pancreatitis and acute kidney injury and was educated on the importance of abstaining from alcohol consumption to prevent recurrence of pancreatitis and further renal complications. Medication management and adherence were reviewed, including the importance of taking medications as prescribed and monitoring for adverse effects. The patient verbalized understanding of the education provided. The patient reported her last bowel movement occurred on the day of assessment and denied constipation, diarrhea, nausea, vomiting, or abdominal discomfort. She also denied dysuria, urinary frequency, urgency, or other urinary complaints. Appetite remains poor, and the patient reported decreased oral intake, placing her at continued risk for nutritional compromise given her history of malnutrition. Education was provided regarding the importance of maintaining adequate hydration and nutritional intake to support recovery and overall health. The patient reported sleeping well and denied recent falls. Skin assessment revealed no open wounds, pressure injuries, or areas of concern. Mobility assessment demonstrated impaired ambulation requiring the use of both a walker and cane, with one-person assistance recommended for safe mobility and fall prevention. The patient remains at increased risk for falls due to generalized weakness, deconditioning, and ambulatory difficulties following hospitalization. Skilled nursing services are indicated for ongoing assessment of cardiopulmonary and gastrointestinal status, monitoring for recurrence of pancreatitis symptoms, evaluation of renal function status, medication management and education, nutritional assessment, reinforcement of alcohol cessation counseling, and fall prevention education. The plan of care includes continued skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> to monitor the patient's recovery, promote medication compliance, reinforce disease process education, support nutritional improvement, and maximize safety and independence within the home environment.
 Date of Order 06/08/2026 Orders Physician Face-to-Face Date: 06/01/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat due to Alcohol-induced chronic pancreatitis Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/08/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Michael Durry
700 Washington Blvd
Baltimore, MD 21230
PHONE: 4103838300 FAX: 14107355227 NPI: 1255319950

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 : 06/01/2026

27. Attending Physician's Signature and Date Signed **06/16/2026**: 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: 1150/19536

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
AA00019540	06/08/2026	From: 06/08/2026 To: 08/06/2026	26642	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Louise Minor 2024 N SMALLWOOD ST, BALTIMORE, MD 21216 410-736-3161	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

home
 1 - SOC - SN Notes: soc
 Physician Durry, Michael

SN Careplans

SN WK1: 1 (06/08/26-06/13/26) ,WK2: 1 (06/14/26-06/20/26) ,WK3: 1 (06/21/26-06/27/26) ,WK4: 1 (06/28/26-07/04/26) ,WK5: 1 (07/05/26-07/11/26) ,WK6: 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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 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 ; 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.

No open wounds noted
Advance Directive:Not Received

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102c - Med Admin, meal preparation, Home Safety, M2020 - Oral Med Management, abnormal blood pressure, M1400 - Dyspnea, M1033 - Exhaustion, abn cholesterol > 200 mg/dL, abnormal electrolyte panel, heartburn/indigestion, limited endurance, limited strength, muscle spasms, muscle weakness, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, weak hand grips, balance deficit, pain radiating to arms/legs, loss of appetite

PROCEDURES: cough/deep breathing exercises, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals, coordinate/arrange repair of inadequate lighting

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, * 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, patient living environment has adequate lighting, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately

SN Goals

PATIENT-STATED GOAL: To decrease back pain and abstaining from ETOH consumption

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
* 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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient living environment has adequate lighting

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

meal preparation is available to patient for all meals

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	06/08/2026