Home Health Certification and Plan of Care

Order ID: 1150/20912

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
11353003	07/28/2026	From: 07/28/2026 To: 09/25/2026	28509	217058

6. Patient's Name and Address
Mariam Ata
1808 Severn HIlls Ln,
SEVERN, MD 21144-
609-202-8746

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 05/26/1999 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
K35.32	Ac appendicitis w perf loc peritonitis & gangr w/o abscs	07/28/26

13. ICD	Other Pertinent Diagnoses	Date
Z45.2	Encounter for adjustment and management of VAD	07/28/26
Z79.2	Long term (current) use of antibiotics	07/28/26
N80.123	Deep endometriosis of bilateral ovaries	07/28/26
F32.A	Depression unspecified	07/28/26
F41.1	Generalized anxiety disorder	07/28/26
D50.9	Iron deficiency anemia unspecified	07/28/26
E55.9	Vitamin D deficiency unspecified	07/28/26

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
Zofran - Ondansetron Hydrochloride eq 4 mg base by mouth as necessary Nausea
Flagyl - Metronidazole 500 mg by mouth twice a day Infection
Ceftriaxone - Ceftriaxone Sodium eq 2gm base/vial 1 DOSE intravenous once a day DAILY THROUGH 8/8/2026

14. DME and Supplies:
IV supplies

15. Safety Measures:
cardiac precautions, infectious material management, standard precautions, hand rails, fall precautions, smoke detectors , medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, sharps precautions, activity supervision, bathroom safety

16. Nutrition:
low fiber

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
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: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

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
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Acute appendicitis with perforation, localized peritonitis, and gangrene, without abscess, 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 27-year-old female who was referred for home health services following an emergency department visit for a ruptured appendix requiring surgical intervention. She was discharged home with prescribed antibiotic therapy. Her past medical history was reviewed, and medication reconciliation was completed with no significant discrepancies noted. During today's assessment, the patient was alert and oriented, reporting mild postoperative abdominal discomfort but denying fever, chest pain, nausea, or vomiting. Respiratory assessment revealed clear lung sounds bilaterally with no signs of respiratory distress. The patient reported normal urinary function without dysuria or retention, and bowel assessment demonstrated normoactive bowel sounds with no gastrointestinal concerns reported. No wounds or additional skin integrity issues were identified during the visit. Vital signs were monitored and remained stable, with no evidence of acute infection or postoperative complications. Skilled nursing education was provided to the patient and her husband regarding the importance of monitoring vital signs for early recognition of infection or other postoperative complications, adherence to the prescribed intravenous antibiotic regimen, and the importance of completing the full course of therapy as ordered. Comprehensive instruction and return demonstration were completed on proper hand hygiene techniques to reduce the risk of infection associated with IV therapy and postoperative recovery. Both the patient and caregiver verbalized understanding of the education provided and demonstrated appropriate handwashing technique. The patient was instructed to promptly report any fever, increasing abdominal pain, redness, swelling, drainage, or other signs of infection to her healthcare provider. The plan of care includes continued skilled nursing visits for ongoing assessment, monitoring of postoperative recovery, evaluation of the patient's response to antibiotic therapy, reinforcement of infection prevention education, and coordination of care with the physician as needed.
 Date of Order 07/28/2026 Orders Physician Face-to-Face Date: 07/25/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management due to Acute appendicitis with perforation, localized peritonitis, and gangrene, without abscess 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 iNFUSION
 Physician Ghafoor, Asad

SN Careplans

SN WK1: 2 (07/28/26-08/01/26) ,WK2: 2 (08/02/26-08/08/26) ,WK3: 2 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26) ,WK6: 1 (08/30/26-09/05/26) ,WK7: 1 (09/06/26-09/12/26)

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: 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; Assess the patient's incision on post op day 7 and the

SN Goals

PATIENT-STATED GOAL: To be infection free

GOALS
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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/28/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Asad Ghafoor
12201 Plum Orchard Drive
Silver Spring, MD 20904
PHONE: 3015721000 FAX: NPI: 1598915621

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 : 07/25/2026

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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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, M2102f - Patient Supervision, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, nausea/vomiting, limited strength (MS), limited endurance (MS), muscle weakness (MS), balance deficit, loss of appetite (NU)

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, infusion therapy: Give iv antibiotics and change PICC dressing every 7 days IV (ceftriaxone 2 gr iv daily thru 8/8/26. midline. pharmacy:burke. statpoint to provide

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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 is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

* recalls related medication(s) purpose, schedule

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/28/2026