Home Health Certification and Plan of Care

Order ID: 1150/19449

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2MF8PN2GK41	06/06/2026	From: 06/06/2026 To: 08/04/2026	26635	217058

6. Patient's Name and Address
Nancy Conaway
160 South River Landing Road,
Edgewater, MD 21037-
301-318-0593

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 05/16/1947 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z48.3	Aftercare following surgery for neoplasm	06/06/26

13. ICD	Other Pertinent Diagnoses	Date
Z90.11	Acquired absence of right breast and nipple	06/06/26
C50.911	Malignant neoplasm of unsp site of right female breast	06/06/26
I27.24	Chronic thromboembolic pulmonary hypertension	06/06/26
E78.00	Pure hypercholesterolemia unspecified	06/06/26
D68.51	Activated protein C resistance	06/06/26
K59.00	Constipation unspecified	06/06/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	06/06/26
Z86.711	Personal history of pulmonary embolism	06/06/26
Z79.01	Long term (current) use of anticoagulants	06/06/26

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

Bupropion Hydrochloride - Bupropion Hydrochloride Extended Release 24 Hour 300 MG / 1 Tablet by mouth EVERY DAY
ROSUVASTATIN CALCIUM 10 mg / 1 Tablet by mouth EVERY DAY
XARELTO 20 mg / 1 Tablet by mouth EVERY DAY
Extra Strength Tylenol - Acetaminophen 500 mg, Take 2 tablet (1,000 mg total) by mouth as necessary For pain
Colace - Docusate Sodium 100 mg I tab by mouth twice a day For constipation
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tablet by mouth once a day

14. DME and Supplies:
None of the above

15. Safety Measures:
standard precautions, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
demerol meperidine sulfa antibiotics

18.A. Functional Limitations
None of the above

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: 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
patient will be responsible for managing treatment

Homebound status: After undergoing Total right breast mastectomy, 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 female with a past medical history significant for right breast carcinoma, status post total right breast mastectomy. Upon arrival, the patient was observed resting comfortably in the living room. The patient's husband and sister were present throughout the visit and actively involved in the discussion of care. Patient was alert and oriented to person, place, and time (A&O x3) and denied pain or discomfort at the time of assessment. Assessment of the surgical site revealed the incision to be clean, dry, and intact with no signs of redness, drainage, dehiscence, or infection noted. Jackson-Pratt (JP) drains were in place and functioning appropriately, with minimal drainage observed during the visit. Drain insertion sites appeared intact without evidence of complications. The patient was assessed for postoperative concerns and demonstrated no acute distress. Admission paperwork was reviewed and completed with the patient and family. Medication reconciliation was performed, and all prescribed medications were available in the home. No missing medications, discrepancies, or refill needs were identified at this time. The patient verbalized understanding of her medication regimen and agreed with the proposed plan of care. Patient was admitted to home health services for ongoing skilled nursing assessment and management of the postoperative surgical site and JP drains. Education was provided regarding incision care, JP drain management, signs and symptoms of infection, proper hand hygiene, medication compliance, and when to notify the physician of any changes in condition, including increased drainage, redness, swelling, fever, or worsening pain. The patient and family demonstrated understanding of the teaching provided. Skilled nursing services will continue to monitor surgical wound healing, JP drain output and function, overall postoperative recovery, medication management, and patient safety. Ongoing assessment and education will be provided to promote healing, prevent complications, and support recovery in the home setting.
 Date of Order 06/06/2026 Orders Physician Face-to-Face Date: 05/28/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management due to Total right breast mastectomy 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 Friedman, Neil

SN Careplans

SN WK1: 1 (06/06/26-06/06/26) ,WK2: 1 (06/07/26-06/13/26) ,WK3: 2 (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) ,WK7: 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

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

SN Goals

PATIENT-STATED GOAL: My sure my wounds heal well and to remove

GOALS
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

meal preparation is available to patient for all meals

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

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

25. Date HHA Received Signed POT

24. Physician's Name and Address
Neil Friedman
227 Saint Paul Place
Baltimore, MD 21202
PHONE: 4103329330 FAX: 14103471175 NPI: 1538103676

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 : 05/28/2026

27. Attending Physician's Signature and Date Signed **07/08/2026**: 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.

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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, meal preparation, M1400 - Dyspnea, limited strength, limited range of motion, red/tender pressure points

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange preparation of missing meals

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, patient self-administers medications as prescribed, 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	06/06/2026