Home Health Certification and Plan of Care

Order ID: 1150/21398

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
37072057	08/17/2026	From: 08/17/2026 To: 10/15/2026	27185	217058

6. Patient's Name and Address

Frances Sprouse
8016 Grayhaven Road,
Dundalk, MD 21222-
443-764-3016

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 09/11/1949 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z48.815	Encntr for surgical aftcr following surgery on the dgstv sys	08/17/26

13. ICD	Other Pertinent Diagnoses	Date
K86.2	Cyst of pancreas	08/17/26
E10.9	Type 1 diabetes mellitus without complications	08/17/26
I26.99	Other pulmonary embolism without acute cor pulmonale	08/17/26
I10.	Essential (primary) hypertension	08/17/26
D51.0	Vitamin B12 defic anemia due to intrinsic factor deficiency	08/17/26
S52.021D	Disp fx of olecran pro w/o intartic extn r ulna 7thD	08/17/26
S52.501D	Unsp fx the lower end r rad subs for clos fx w routn heal	08/17/26
S92.101D	Unsp fracture of right talus subs for fx w routn heal	08/17/26
S52.611D	Disp fx of r ulna styloid pro subs for clos fx w routn heal	08/17/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	08/17/26
D50.9	Iron deficiency anemia unspecified	08/17/26
E78.5	Hyperlipidemia unspecified	08/17/26
E03.9	Hypothyroidism unspecified	08/17/26
I95.9	Hypotension unspecified	08/17/26
I25.2	Old myocardial infarction	08/17/26
E53.8	Deficiency of other specified B group vitamins	08/17/26
R13.10	Dysphagia unspecified	08/17/26
D69.6	Thrombocytopenia unspecified	08/17/26
F10.10	Alcohol abuse uncomplicated	08/17/26
Z79.01	Long term (current) use of anticoagulants	08/17/26
Z85.831	Personal history of malignant neoplasm of soft tissue	08/17/26
Z85.3	Personal history of malignant neoplasm of breast	08/17/26
Z90.12	Acquired absence of left breast and nipple	08/17/26
Z91.81	History of falling	08/17/26

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

Tylenol - Acetaminophen 650 mg by mouth as necessary Every 6 hours. PRN Reasons: Mild pain (1-3). May also be administered per patient/Legally Authorized Health Care Decision-Maker (LAHD) preference for >3 pain score., Moderate pain (4-6). May also be administered per patient/Legally Authorized Health Care Decision-Maker (LAHD) preference for > 6 pain score., Temperature > 38.5 (101.3 F)
Creon - Pancrelipase (Amylase:Lipase:Protease) 36,ooo-114,000-180,000, 2 cap by mouth three times a day
Zofran Odt - Ondansetron 4 mg Take 1 tablet by mouth every 8 hours As needed for Nausea
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, 1 tablet by mouth every 4 hours As Needed for pain
Protonix - Pantoprazole Sodium eq 40 mg base Take 1 tablet by mouth once a day
Aspirin 81Mg - Aspirin Take 1 tablet by mouth twice a day
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50mcg(2000 unit) take 1 capsule by mouth once a day
Celexa - Citalopram Hydrobromide eq 20 mg base Take 1 tablet by mouth once a day
Vitamin B12 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000mcg/ml, inject 1 ml intramuscular monthly Done by PCP
SYNTHROID 88 mcg OG tube Daily
COZAAR 100 MG mg Oral Daily
TOPROL-XL 100 mg Oral Nightly Admin Instructions: Hold for SBP < 90, MAP < 65, HR < 60 Do not crush or chew.
SENOKOT 8.6 mg/tablett / Take 2 tablets Oral twice a day As needed for constipation
NORVASC eq 10 mg base mg Oral Daily
LIPITOR mg Oral Nightly
Novolog - Insulin Aspart Recombinant 0-8 Units subcutaneous three times a day During meals. Admin Instructions: CORRECTIONAL: medium dose If nutritional dose given, give correctional dose AFTER meal together WITH nutritional dose. If nutritional dose is held (e.g., patient is eating poorly, NPO, tube feeding is held), correctional dose should still be given.
Novolog - Insulin Aspart Recombinant 9 Units subcutaneous three times a day During meals. Admin Instructions: Administer this NUTRITIONAL dose AFTER patient has consumed 50% of the carbohydrates of the meal (solid food) or AFTER completion of the bolus (Bolus Tube Feed). Hold nutritional insulin if NPO or no tube feeding.
NOVOLOG 0-5 Units SubQ Nightly Admin Instructions: CORRECTIONAL: medium dose If NPO or eating poorly, still give correctional dose. RN to check POC BG three hours after administration to assure the patient is not hypoglycemic.
LANTUS 12 Units SubQ at bedtime Admin Instructions: Do NOT hold this BASAL dose without consulting prescriber. ***Insulin syringe MUST be used for administration***

14. DME and Supplies:

wheelchair, hand held shower, commode, bath bench, cane

15. Safety Measures:

standard precautions, medication safety, fall precautions, diabetic precautions, bathroom safety, ambulates with device

16. Nutrition:

diabetic

17. Allergies:

shellfish!adhesive bandages sulfa adhesive tape latex

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Cane

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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 08/17/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Diaa Mikhail
1005 Northpoint Blvd
Baltimore, MD 21222
PHONE: 4102885901 FAX: 14102885904 NPI: 1558391227

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 : 08/11/2026

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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Homebound status: After undergoing Whipple procedure, 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 76-year-old female with a past medical history significant for hypertension, type 1 diabetes mellitus, hypothyroidism, chronic arterial disease, and breast sarcoma status post left mastectomy. She was recently found to have a pancreatic cyst incidentally identified on imaging obtained following a fall that resulted in right elbow/forearm and right foot fractures, for which she underwent open reduction and internal fixation (ORIF) and was subsequently transferred to a rehabilitation facility. On the last day of rehabilitation, the patient was hospitalized for diabetic ketoacidosis, during which abdominal imaging revealed the pancreatic cyst. She subsequently underwent a Whipple procedure. During her hospitalization, she initially had two surgical drains; one was removed prior to discharge, and the second was removed before discharge with a drainage pouch placed over the former drain site. At the time of the home health visit, the drainage pouch was intact and empty, as the patient had emptied it prior to the visit. The patient is alert and oriented x4 and resides alone in a townhouse with six steps and a railing. Her son, who is her primary caregiver, lives with his family nearby and <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> daily. To minimize stair negotiation during recovery, a kitchen area has been established on the upper level near the patient's bedroom and bathroom. The mid-upper abdominal surgical incision was observed with Steri-Strips intact. The patient reports following postoperative instructions to shower and gently pat the surgical site dry, with her son assisting when present. Nursing education was provided regarding care and monitoring of the drainage pouch, including appropriate observation for changes or complications. The patient has a scheduled PCP appointment on 08/19/2026 and anticipates receiving further postoperative instructions and follow-up recommendations at that time. The patient uses a Dexcom G6 continuous glucose monitoring system, with the sensor currently placed on the posterior aspect of the right hand, for ongoing blood glucose monitoring. Medication reconciliation and review were completed. The patient demonstrated knowledge of her insulin administration procedure and was able to verbalize the prescribed sliding-scale regimen. She denies shortness of breath, headache, nausea, vomiting, or significant pain but reports discomfort around the surgical site and generalized fatigue/exhaustion. Vital signs were within normal limits, and respirations were even and unlabored. She ambulates slowly throughout the home without an assistive device but uses a cane when leaving the home. Prior to her recent hospitalization and decline in functional status, the patient was independent with community ambulation without an assistive device and was independent with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Physical therapy assessment identifies significant functional decline following hospitalization and surgery. The patient demonstrates impaired balance, with a Tinetti Performance-Oriented Mobility Assessment score of 14/28, indicating increased fall risk, and a Timed Up and Go (TUG) score of 16.8 seconds. She presents with unsteady gait without an assistive device, difficulty negotiating the stairs in her home, lower-extremity weakness, impaired balance, and decreased activity tolerance/endurance. Although she is currently able to ambulate within the home without an assistive device, her slow and unsteady mobility places her at increased risk for falls and limits safe functional mobility and community access. Skilled physical therapy is indicated to address lower-extremity weakness, balance impairment, gait instability, stair negotiation, decreased endurance, and overall functional decline with the goal of improving safety and progressing the patient toward her prior level of function. The patient was educated on the importance of gradually increasing cardiovascular activity as tolerated, including regular walking, and was instructed to track and log the duration of her walks to monitor activity progression. Initial education and therapeutic exercises targeting the lower extremities were initiated. Continued skilled nursing services are warranted for postoperative assessment, surgical-site and drainage-pouch monitoring, medication management, diabetes and insulin-management education, and ongoing assessment for complications following the Whipple procedure and recent hospitalization. Continued skilled physical therapy is recommended to improve strength, balance, gait, endurance, stair safety, and functional independence while reducing fall risk and supporting a safe return to her prior level of function.
 Date of Order 08/17/2026 Orders Physician Face-to-Face Date: 08/11/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat hha-adl's due to Whipple procedure 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 PT Eval Notes:
 Physician Mikhail, Diaa

SN Careplans

SN WK1: 1 (08/17/26-08/22/26) ,WK2: 1 (08/23/26-08/29/26) ,WK3: 1 (08/30/26-09/05/26) ,WK4: 1 (09/06/26-09/12/26) ,WK5: 1 (09/13/26-09/15/26)

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, 8. Currently reports exhaustion, 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

SN Goals

PATIENT-STATED GOAL: Patient goal

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
* 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

patient has access to necessary medical care considering inability to pay

patient is adequately supervised

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
08/17/2026

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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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, Financial, M2102f - Patient Supervision, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, limited strength, balance deficit, swell/redness surround. skin, #1 - Observable Surgical Wound - Anterior Midline - Mid upper abdominal surgical site, #2 - Observable Surgical Wound - Anterior Right Abdomen - Two drain sites that are covered with a drainage pouch.

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Midline - Mid upper abdominal surgical site, physician-ordered wound care: #2 - Observable Surgical Wound - Anterior Right Abdomen - Two drain sites that are covered with a drainage pouch., cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: Mid upper abdominal area: Leave open to air., glucose testing via monitor, coordinate/arrange for adequate patient supervision

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 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, patient has access to necessary medical care considering inability to pay, patient is adequately supervised, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (08/17/26-08/22/26) ,WK2: 2 (08/23/26-08/29/26) ,WK3: 1 (08/30/26-09/05/26) ,WK4: 1 (09/06/26-09/12/26) ,WK5: 1 (09/13/26-09/15/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170O1 - 12 Steps, GG0130F1 - Upper Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, GG0170D1 - Sit to Stand, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer

PROCEDURES: Medication management : Review medications with patients, home exercise program: Seated laq, hip flexion, heelraises, toe raises, standing hip abduction, flexion, heelraises hamstring curls, Mini squats all 2-310 as tolerated, equipment training, work simplification/energy conservation, dynamic standing balance exercises: Perform balance exercises to challenge ankle hip and step strategies to improve patient stability and reduce risk for falls., gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To improve my strength and balance improve my endurance. So I can walk longer distances and not be so tired. All the time.

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/17/2026