Home Health Certification and Plan of Care

Order ID: 1150/21468

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
100583790	08/20/2026	From: 08/20/2026 To: 10/18/2026	29303	217058

6. Patient's Name and Address
Ana Vilma Ruiz Del Rivera
306 Park Halls Street,
LAUREL, MD 20724-
240-604-1196

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 12/29/1957 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z48.3	Aftercare following surgery for neoplasm	08/20/26

13. ICD	Other Pertinent Diagnoses	Date
Z90.49	Acquired absence of other specified parts of digestive tract	08/20/26
C17.0	Malignant neoplasm of duodenum	08/20/26
E83.51	Hypocalcemia	08/20/26
I10.	Essential (primary) hypertension	08/20/26
E78.5	Hyperlipidemia unspecified	08/20/26
M81.0	Age-related osteoporosis w/o current pathological fracture	08/20/26
F32.A	Depression unspecified	08/20/26
H91.90	Unspecified hearing loss unspecified ear	08/20/26
M35.3	Polymyalgia rheumatica	08/20/26
G47.00	Insomnia unspecified	08/20/26
K25.9	Gastric ulcer unsp as acute or chronic w/o hemor or perf	08/20/26
E43.	Unspecified severe protein-calorie malnutrition	08/20/26
Z85.3	Personal history of malignant neoplasm of breast	08/20/26
Z79.4	Long term (current) use of insulin	08/20/26
Z96.0	Presence of urogenital implants	08/20/26

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

Thiamine - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tab by mouth once a day supplement
K-PHOS Neutral 250MG; 1 TAB by mouth four times a day WITH MEALS
CREON 36 pancrelipase (Lip-Prot-Amyl) 36,000-114,00-180,000 unit / Take 2 Capsule by mouth three times a day with meals. Admin Instructions: Do not crush or chew. May be opened and beads mixed with apple sauce or thickened liquids.
Augmentin - Amoxicillin: Clavulanate Potassium 875-125 MG / 1 Tablet Oral 2 times daily Admin Instructions: May be given with or without food. for 5 days
Zofran Odt - Ondansetron 0 Disintegrating 4 MG Tablet Oral Every 8 hours PRN PRN Reason: Nausea, Vomiting.
PROTONIX eq 40 mg base EC 40 MG tablet Oral Daily Admin Instructions: Do not crush or chew
ROXICODONE 5 mg 5mg; 1/2 tab Oral Every 4 hours PRN PRN Reason: Moderate pain (4-6).

14. DME and Supplies:
walker

15. Safety Measures:
standard precautions, fall precautions, walker precautions, supervision at all times, transfer with assist, activity supervision

16. Nutrition:
regular

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance

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: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

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
family/caregiver will be responsible for managing treatment

Homebound status: After undergoing Open 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 diagnosed with duodenal adenocarcinoma as of 7/16, with esophagogastroduodenoscopy (EGD) performed on 7/6 revealing an infiltrating moderately differentiated adenocarcinoma involving the second part of the duodenum. The patient is status post open Whipple procedure performed on 8/6/26. Past medical history is significant for breast cancer status post lumpectomy, hypertension, hyperlipidemia, gastric ulcers, obesity, osteoporosis, depression, hearing loss, polymyalgia rheumatica (PMR), and insomnia. The patient is Spanish speaking and requires family assistance with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Skilled nursing is ordered at a frequency of 1W12, 2W1, and 1W1 for continued postoperative and disease management. On assessment, the patient was alert and oriented x3 and reported abdominal pain rated 5/10 and some nausea. The patient denied shortness of breath, and lungs were clear to auscultation throughout. Appetite was reported as fair, and the patient reported a bowel movement today. A midline abdominal incision with Steri-Strips was present. A right upper quadrant (RUQ) JP drain was in place with scant purulent drainage noted. The patient has a walker available for safe ambulation and continues to require family assistance with ADLs and IADLs. Skilled nursing reviewed all medications with the patient and caregivers, including medication doses, frequencies, and pertinent potential side effects. Education was provided regarding consumption of small, frequent meals, measures to help relieve nausea, and proper JP drain care, including monitoring and recording drain output. The spouse and caregiver were receptive to all teaching provided and demonstrated understanding of the instructions. Skilled nursing will continue to monitor the patient's postoperative status, surgical incision and JP drain, pain and nausea, nutritional status, medication management, safety, and functional needs while reinforcing disease-specific and postoperative education throughout the plan of care.
 Date of Order 08/20/2026 Orders Physician Face-to-Face Date: 08/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management due to Open 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
 Physician Delgado Rosado, Gisela

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 08/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Gisela Delgado Rosado
1106 Annapolis Rd Ste 310
Odenton, MD 21113
PHONE: 4108741400 FAX: 14108741812 NPI: 1154812014

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 : 08/06/2026

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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SN WK1: 1 (08/20/26-08/22/26)

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, 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 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:No

08/21/2026 Problems : #1 - Non-Observable Surgical Wound - Other - ML ABDOMEN - UNABLE TO OBSERVE DUE TO STERI STRIPS JPX1 WITH SCANT PURULENT DRAINAGE NOTED
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
dependent edema
balance deficit
limited strength
limited endurance
abdominal pain
nausea/vomiting
bruising/discoloration
meal preparation
D0160 - Depression

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - ML ABDOMEN - UNABLE TO OBSERVE DUE TO STERI STRIPSJPX1 WITH SCANT PURULENT DRAINAGE NOTED: OPEN TO AIR, JP DRAIN CARE: EMPTY DAILY AND RECORD OUTPUT, cough/deep breathing exercises

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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

PATIENT-STATED GOAL: TO FEEL BETTER

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/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
* 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

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	08/20/2026

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