

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115021468

Patient Details				
Patient's HI Claim No. 100583790	Start of Care Date 08/20/2026	Certification Period 08/20/2026 - 10/18/2026	Medical Record No. 29303	Provider No. 217058
Patient's Name and Address Ana Vilma Ruiz Del Rivera 306 Park Halls Street LAUREL, MD 20724		Gender Female	Date of Birth 12/29/1957	Phone Number 240-604-1196
		Email		Primary Language English
Clinical Profile				
Provider's Name HomeCentris Healthcare LLC		Address 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117		Phone Number 410-321-8448
NPI 1487113239				Fax Number 410-559-3002
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.		Physician Statement on 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.		

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	
--	--

ICD-10 CM Principal Diagnosis: Z48.3. Aftercare following surgery for neoplasm

Other Pertinent Diagnoses		
ICD-10 CM	Description	Medications
Z90.49	Acquired absence of other specified parts of digestive tract	Thiamine - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpantenol: 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).
C17.0	Malignant neoplasm of duodenum	
E83.51	Hypocalcemia	
I10.	Essential (primary) hypertension	
E78.5	Hyperlipidemia unspecified	
M81.0	Age-related osteoporosis w/o current pathological fracture	
F32.A	Depression unspecified	
H91.90	Unspecified hearing loss unspecified ear	
M35.3	Polymyalgia rheumatica	
G47.00	Insomnia unspecified	
K25.9	Gastric ulcer unsp as acute or chronic w/o hemor or perf	
E43.	Unspecified severe protein-calorie malnutrition	
Z85.3	Personal history of malignant neoplasm of breast	
Z79.4	Long term (current) use of insulin	
Z96.0	Presence of urogenital implants	

Prognosis fair	Mental and Psychosocial 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
Functional Limitations Ambulation, Endurance	Activities Permitted Walker, Up As Tolerated
DME & Supplies walker	Safety Measures standard precautions, fall precautions, walker precautions, supervision at all times, transfer with assist, activity supervision
Nutrition regular	Allergies no known allergies

Ruiz Del Rivera, Ana Vilma | Cert Period 08/20/26 - 10/18/26

Advance Directives No	Caregiver Status 1. Non-agency caregiver(s) currently provide assistance; 1. Non-agency caregiver(s) currently provide assistance
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.	DISCHARGE PLAN: family/caregiver will be responsible for managing treatment
Orders for Discipline and Treatment: 1 - SOC - SN	
SN CAREPLAN SN frequency 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	SN NARRATIVE PATIENT DX WITH DUODENAL ADENOCARCINOMA 7/16. PMH INCLUDES BREAST CA S/P LUMPECTOMY, HTN, HLD, GASTRIC ULCERS, OBESITY, OSTEOPOROSIS, DEPRESSION, HEARING LOSS, PMR, INSOMNIA, S/P OPEN WHIPPLE PROCEDURE 8/6/26; EDG 7/6 REVEALED AN INFILTRATING MODERATELY DIFFERENTIATED ADENOCARCINOMA, 2ND PART OF THE DUODENUM. SN FREQ 1W12W21W1; FAMILY ASSIST WITH ALL ADL'S AND IADL'S. PT IS SPANISH SPEAKING. PATIENT IS ALERT AND ORIENTED X3; REPORTS PAIN AS 5/10, REPORTS SOME NAUSEA, DENIES SOB, LUNGS CLEAR THROUGHOUT, FAIR APPETITE, LBM TODAY, ML ABDOMINAL INCISION WITH STERI STRIPS, RUQ JP DRAIN WITH SCANT PURULENT DRAINAGE NOTED, PT HAS WALKER FOR SAFE AMBULATION. SN REVIEWED ALL MEDICATIONS, DOSE, FREQUENCY AND PERTINENT SIDE EFFECTS; INSTRUCTED ON CONSUMING SMALL FREQUENT MEALS; MEASURES TO RELIEVE NAUSEA; JP DRAIN CARE AND RECORDING OUTPUT, SPOUSE AND CG RECEPTIVE TO ALL TEACHINGS. ----- PATIENT DX WITH DUODENAL ADENOCARCINOMA 7/16. PMH INCLUDES BREAST CA S/P LUMPECTOMY, HTN, HLD, GASTRIC ULCERS, OBESITY, OSTEOPOROSIS, DEPRESSION, HEARING LOSS, PMR, INSOMNIA, S/P OPEN WHIPPLE PROCEDURE 8/6/26; EDG 7/6 REVEALED AN INFILTRATING MODERATELY DIFFERENTIATED ADENOCARCINOMA, 2ND PART OF THE DUODENUM. SN FREQ 1W12W21W1; FAMILY ASSIST WITH ALL ADL'S AND IADL'S. PT IS SPANISH SPEAKING. PATIENT IS ALERT AND ORIENTED X3; REPORTS PAIN AS 5/10, REPORTS SOME NAUSEA, DENIES SOB, LUNGS CLEAR THROUGHOUT, FAIR APPETITE, LBM TODAY, ML ABDOMINAL INCISION WITH STERI STRIPS, RUQ JP DRAIN WITH SCANT PURULENT DRAINAGE NOTED, PT HAS WALKER FOR SAFE AMBULATION. SN REVIEWED ALL MEDICATIONS, DOSE, FREQUENCY AND PERTINENT SIDE EFFECTS; INSTRUCTED ON CONSUMING SMALL FREQUENT MEALS; MEASURES TO RELIEVE NAUSEA; JP DRAIN CARE AND RECORDING OUTPUT, SPOUSE AND CG RECEPTIVE TO ALL TEACHINGS. SN GOALS 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

bruising/discoloration meal preparation D0160 - Depression PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - ML ABDOMEN - UNABLE TO OBSERVE DUE TO STERILE 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 medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals	* 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
Ruiz Del Rivera, Ana Vilma Cert Period 08/20/26 - 10/18/26	

Signature and Date of Verbal SOC Where Applicable: Electronically signed by: Charles Messick RN on 08/20/2026	
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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services. F2F date: 08/06/2026	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.
Certifying Physician or Allowed Practitioner Name and Address Gisela Delgado Rosado 1106 Annapolis Rd Ste 310 Odenton, MD 21113 NPI 1154812014	Phone Number 4108741400 Fax Number 14108741812
Physician's Signature and Date Signed X Gisela Delgado Rosado, MD 08/06/2026: Date of physician last face-to-face	
Ruiz Del Rivera, Ana Vilma Cert Period 08/20/26 - 10/18/26	