Home Health Certification and Plan of Care

Order ID: 1150/15825

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
16306843	01/24/2026	From: 01/24/2026 To: 03/24/2026	21771	217058

6. Patient's Name and Address
Pearlie Grey
3349 Shrewsbury Rd,
ABINGDON, MD 21009-
443-310-1357

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 05/23/1934 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
E87.6	Hypokalemia	01/24/26

13. ICD	Other Pertinent Diagnoses	Date
G30.9	Alzheimer's disease unspecified	01/24/26
F02.80	Dem in oth dis classd elswhrunsp sevw/o beh/psych/mood/anx	01/24/26
J44.1	Chronic obstructive pulmonary disease w (acute) exacerbation	01/24/26
I11.0	Hypertensive heart disease with heart failure	01/24/26
I50.9	Heart failure unspecified	01/24/26
E78.5	Hyperlipidemia unspecified	01/24/26
M48.00	Spinal stenosis site unspecified	01/24/26
K59.00	Constipation unspecified	01/24/26
K21.9	Gastro-esophageal reflux disease without esophagitis	01/24/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	01/24/26
Z87.01	Personal history of pneumonia (recurrent)	01/24/26
Z87.440	Personal history of urinary (tract) infections	01/24/26
Z79.52	Long term (current) use of systemic steroids	01/24/26

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

Melatonin - Melatonin 3 MG Tabs tablet by mouth nightly
Oseltamivir Phosphate - Oseltamivir Phosphate 30 MG by mouth 2 times daily for 2 days Commonly known as: TAMIFLU
Biscodyl - Bisacodyl: Polyethylene Glycol 3350: Potassium Chloride: Sodium Bicarbonate: Sodium Chloride 17 g packet by mouth daily Commonly known as: MIRALAX. Start taking on: January 22, 2026
Acetated Ringer'S In Plastic Container - Calcium Chloride: Potassium Chloride: Sodium Acetate: Sodium Chloride 280-160-250 MG packet by mouth 4 times daily - after meals & nightly for 3 days Commonly known as: PHOS-NAK
Betapar - Meprednisone 20 MG tablet by mouth daily x 2 days then daily x2 days Do not start before January 22, 2026. Start taking on: January 22, 2026
Amilodipine - Amlodipine Besylate 5 MG tablet by mouth daily Commonly known as: NORVASC
Calcium Carbonate, Famotidine And Magnesium Hydroxide - Calcium Carbonate: Famotidine: Magnesium Hydroxide 40 MG tablet by mouth daily Commonly known as: PEPCID
Gabapentin - Gabapentin 300 MG capsule by mouth 2 times daily Commonly known as: NEURONTIN
Cozaar - Losartan Potassium 50 MG tablet by mouth daily Take 2 tablets. Commonly known as: COZAAR
Ezetimibe And Simvastatin - Ezetimibe: Simvastatin 20 mg 1tablet by mouth once a day Commonly known as: ZOCOR

14. DME and Supplies:
wheelchair, commode, wound care supplies

15. Safety Measures:
smoke detectors , ambulates with device, ambulates with assistance, , supervision at all times, transfer with assist, wheelchair precautions, , , , activity supervision

16. Nutrition:
soft

17. Allergies:
blue crab penicillins

18.A. Functional Limitations
Bowel/Bladder Incontinence, Endurance, Ambulation, Hearing

18.B. Activities Permitted
Wheelchair, Transfer bed/Chair, Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 3. Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time., ANXIETY: 4. Constantly, SOCIAL ISOLATION: 8. Patient unable to respond, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions!5. Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions), HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans
family/caregiver will be responsible for managing treatment

Homebound status:
Due to diagnosis of Hypokalemia, 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 91-year-old female who was recently sent to UCH for evaluation of a suspected bowel obstruction and was subsequently diagnosed with influenza. She currently resides in Abingdon with her daughter in a single-family home, occupying a bedroom on the main living level. The patient has a significant past medical history of Alzheimer's disease, severe dementia, hypertension, and hyperlipidemia. She is non-ambulatory and requires extensive assistance with mobility; although she can stand and pivot, she requires a two-person assist for all transfers. Durable medical equipment in the home includes a wheelchair and a bedside commode, which she uses for toileting. During the start-of-care assessment, the patient was observed holding and interacting with a pretend baby and engaging with two busy blankets, consistent with advanced dementia-related behaviors. Discharge documentation from the hospital recommends a palliative approach to care moving forward. The patient is currently a full code. She has incontinence-associated skin breakdown noted on the buttocks; photographs were obtained at the start of care, though image quality was poor due to darkness. The caregiver has been applying barrier cream daily; however, skilled nursing provided education to reapply barrier cream with every brief change, cleanse only soiled areas gently, and avoid excessive washing to protect skin integrity. All prescribed medications are present in the home. A hospital bed is required to support safe positioning and care needs, and physical therapy is requested to initiate a durable medical equipment order for a hospital bed. The caregiver requires ongoing education regarding dementia progression, disease processes, medication management, dementia-specific care protocols, safe transfer techniques, and maintaining adequate hydration. The patient has a home in Baltimore City and plans to return there with a 24-hour paid caregiver, though this transition will not occur in the immediate future. Skilled nursing is initiating referrals for a home health aide and occupational therapy to support caregiver education, patient safety, and activities of daily living, with continued monitoring of skin integrity, functional status, and overall comfort as part of the plan of care.
 Date of Order 01/24/2026 Orders Physician Face-to-Face Date: 01/21/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat due to Hypokalemia Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 <span

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/24/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Elie Cheikh
6701 N Charles St
Baltimore, MD 21204
PHONE: FAX: NPI: 1649452012

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 : 01/21/2026

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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style="font-size: 14px;">1 - SOC - SN Notes: soc PT Eval Notes: Physician Cheikh, Elie

SN Careplans

SN WK1: 8 (01/24/26-01/24/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 7. Currently taking 5 or more medications, 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 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: , M1700 - Cognition, M1745 - Behavioral Issues, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, dependent edema, coughing, M1400 - Dyspnea, M1033 - Exhaustion, M1620 - Bowel Incontinence, diarrhea, constipation, M1610 - Urinary Incontinence, M1600 - UTI, muscle weakness, limited range of motion, poor muscle tone, limited endurance, limited strength, B0200 - Hearing Deficit, B1000 - Vision Deficit, balance deficit, weak hand grips, daytime fatigue, swell/redness surround. skin, skin breakdown r/t incontinence, #1 - Other - Other - Buttocks - Incontinence related skin breakdown on both left and right buttocks. Barrier cream to Buttocks at every brief change.

PROCEDURES: physician-ordered wound care: #1 - Other - Other - Buttocks - Incontinence related skin breakdown on both left and right buttocks. Barrier cream to Buttocks at every brief change., cough/deep breathing exercises, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, coordinate/arrange for adequate patient supervision, coordinate/arrange resources for vision-impaired, coordinate/arrange home modifications for hearing impaired, i.e. alarms

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 medicatio, * how to keep home safe for patient with dementia coping strategies for the caregiver, 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, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s)

SN Goals

PATIENT-STATED GOAL: CG states she wants the patient to get stronger so she can help more when being transferred to and from the commode.

GOALS
patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver
* 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 medicatio

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
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin 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/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/24/2026

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purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/C O2 alarms, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
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