Home Health Certification and Plan of Care

Order ID: 1150/17373

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
171040323	03/21/2026	From: 03/21/2026 To: 05/19/2026	23865	217058

6. Patient's Name and Address
Ghislain St. Denis
1117 Leonard Drive,
Glen Burnie, MD 21060-
410-487-4853

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 07/28/1944 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
C44.42	Squamous cell carcinoma of skin of scalp and neck	03/21/26

13. ICD	Other Pertinent Diagnoses	Date
C77.9	Secondary and unsp malignant neoplasm of lymph node unsp	03/21/26
Z43.1	Encounter for attention to gastrostomy	03/21/26
R13.10	Dysphagia unspecified	03/21/26
K59.00	Constipation unspecified	03/21/26
K21.9	Gastro-esophageal reflux disease without esophagitis	03/21/26
R10.9	Unspecified abdominal pain	03/21/26

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

Saliva Stimulant Combo (BIOTENE MOISTURIZING MOUTH) MM Spray 1-2 sprays by mouth as needed for Radiation related dry mouth
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5mg/5ml; 5-10ml by mouth every 4-6 hours as needed for pain
Jevity - Jevity 1.5; 6 cans PEG TUBE once a day via feeding tube
Miralax - Polyethylene Glycol 3350 17gm/scoopful 17gm; 1 dose PEG TUBE once a day as needed for constipation

14. DME and Supplies:
walker, cane, TUBE FEEDING SUPPLIES

15. Safety Measures:
ambulates with device, walker precautions, aspiration precautions, ambulates with assistance, transfer with assist, supervision at all times, activity supervision

16. Nutrition:
NG feeding

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Walker, Cane, 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: No

20. Prognosis: poor

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: Due to diagnosis of Squamous Cell Carcinoma Of Skin Of Scalp And Neck, 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 has a history of metastatic squamous cell carcinoma of the head and neck, status post neck dissection, with known metastases to the liver. The patient was also diagnosed with dysphagia requiring gastrostomy tube placement for nutritional support. The patient recently experienced constipation, which has since resolved, with the last bowel movement reported as yesterday. Skilled nursing services are ordered at a frequency of once weekly for 12 weeks, then twice weekly for 1 week, followed by once weekly for 3 weeks. The patient resides with family, and sons assist with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. The patient is scheduled for a PET scan on Tuesday. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient is alert and oriented to person, place, and time. The patient denies pain while at rest but reports some discomfort with movement. The patient also reports shortness of breath with exertion; lung sounds are clear to auscultation. The patient continues to receive enteral nutrition via gastrostomy tube. Physical <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> revealed trace edema in the right lower extremity. During the visit, the skilled nurse reviewed instructions related to gastrostomy tube care and administration of enteral feedings. Education included proper feeding techniques, tube maintenance, and flushing protocols. The gastrostomy tube dressing was changed, and two cans of Jevity 1.5 with a water flush were administered without difficulty. The patient tolerated the feeding well. Both the patient and caregiver were receptive to teaching and demonstrated understanding of the care instructions. The plan is to continue skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> as ordered, reinforce education, monitor nutritional status and respiratory symptoms, and follow up after the scheduled PET scan.
 Date of Order 03/21/2026 Orders Physician Face-to-Face Date: 02/10/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">Assessment</mh> & Education for diseases/conditions/medications due to Squamous Cell Carcinoma Of Skin Of Scalp And Neck 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 Madah, Maria

SN Careplans

SN WK1: 1 (03/21/26-03/21/26) ,WK2: 2 (03/22/26-03/28/26) ,WK3: 1 (03/29/26-04/04/26) ,WK4: 1 (04/05/26-04/11/26) ,WK5: 1 (04/12/26-04/18/26) ,WK6: 1 (04/19/26-04/25/26) ,WK7: 1 (04/26/26-05/02/26)

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: 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, 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

SN Goals

PATIENT-STATED GOAL: TO FEEL BETTER

GOALS
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
* 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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/21/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Maria Madah
1701 Twin Springs Rd
Halethorpe, MD 21227
PHONE: (800) 777-7904 FAX: 18559024974 NPI: 1952892846

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 : 02/10/2026

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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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, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, constipation, cough/gag/pain chew/swallow, muscle weakness, limited endurance, limited strength, Pain Interference with ADLs, weak hand grips, balance deficit, #1 - Other - Anterior Left Abdomen - G-tube, #2 - Other - Anterior Right Upper Chest - BD implanted port for chemotherapy

PROCEDURES: physician-ordered wound care: #2 - Other - Anterior Right Upper Chest - BD implanted port for chemotherapy, physician-ordered wound care: #1 - Other - Anterior Left Abdomen - G-tube, cough/deep breathing exercises, physician-ordered wound care, wound vacuum, administer tube feeding: JEVITY 1.5 2 CANS BOLUS EVERY 4-5 HOUR OR 1 CAN EVERY 2-3 HOURS AS TOLERATED; 30-60ML WATER FLUSHES BEFORE MEDICATIONS AND TUBE FEEDING; 1400ML FREE WATER VIA FLUSHES THROUGHOUT THE DAY., monitor intake & output

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, * 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

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
* 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	03/21/2026