Home Health Certification and Plan of Care

Order ID: 1150/18380

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
86324694	04/30/2026	From: 04/30/2026 To: 06/28/2026	25344	217058

6. Patient's Name and Address

Sukhmandip Grewal
6950 Heritage Xing,
Glen B urnie, MD 21060-
443-354-2429

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 10/13/1973 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
C15.9	Malignant neoplasm of esophagus unspecified	04/30/26

13. ICD	Other Pertinent Diagnoses	Date
J91.0	Malignant pleural effusion	04/30/26
R18.0	Malignant ascites	04/30/26
I82.412	Acute embolism and thrombosis of left femoral vein	04/30/26
Z51.5	Encounter for palliative care	04/30/26
K21.9	Gastro-esophageal reflux disease without esophagitis	04/30/26
Z79.01	Long term (current) use of anticoagulants	04/30/26
Z86.711	Personal history of pulmonary embolism	04/30/26

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

Methylphenidate Hydrochloride - Methylphenidate Hydrochloride 5 mg 5mg; 1 tab by mouth once a day add dose early afternoon to help with fatigue
SIMETHICONE 40 MG/0.6ML drops into tube Place into tube 4 times daily. for gas relief
DULOXETINE HYDROCHLORIDE 60 mg 60 mg capsule delayed release particles mouth daily. depression
PANTOPRAZOLE 40 mg tablet delayed release mouth 2 times daily. stomach
ONDANSETRON 4 mg 4 mg disintegrating tablet mouth every 8 hours as needed for Nausea. for nausea and vomiting
BACLOFEN 10 mg 10 MG tablet mouth 3 times daily as needed for Other. muscle spasms
MORPHINE 15 MG CR tablet mouth every 4 hours as needed for pain
SENNA 8.6 MG Tabs mouth 2 times daily. bowel regimen
DICYCLOMINE 10 MG capsule mouth 3 times daily.
FENTANYL 25 MCG/HR patch onto the skin Place onto the skin every 72 hours. pain
Enoxaparin Sodium - Enoxaparin Sodium 80mg/o.8ml subcutaneous twice a day Inject 0.75 mls into the skin 2 times a day

14. DME and Supplies:

bath bench, wound care supplies, hospital bed, feeding tube supplies, cane

15. Safety Measures:

standard precautions, fall precautions, bleeding precautions, ambulates with device, medication safety, aspiration precautions, ambulates with assistance, transfer with assist, supervision at all times, sharps precautions, anticoagulant precautions, activity supervision

16. Nutrition:

G-Tube

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Exercises Prescribed, Up As Tolerated

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: Yes

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 Malignant neoplasm of esophagus unspecified, 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 52-year-old male with a complex medical history significant for metastatic esophageal cancer status post chemotherapy (currently on hold), deep vein thrombosis, recurrent hyponatremia, dysphagia, severe protein-calorie malnutrition, and the presence of a gastrostomy tube and portacath. The patient was recently hospitalized due to recurrent ascites and pleural effusions requiring thoracentesis and paracentesis, complicated by hypotension likely secondary to volume depletion following large-volume fluid removal. He has since been discharged home and is now receiving home health services for ongoing management and rehabilitation. On assessment, the patient is alert and oriented to person, place, and time, and able to respond appropriately. He reports ongoing discomfort related to bilateral PleurX catheters, as well as pain with standing and in the morning, which is currently managed with prescribed analgesics per medication profile. He also endorses shortness of breath with exertion. Respiratory assessment reveals diminished lung sounds bilaterally, with PleurX catheters present on both the right and left sides; dressings are intact with no immediate signs of complication. The patient demonstrates a dusky skin tone and has noted pitting edema of the lower extremities, with measurements documented (right foot 9.75 cm, left foot 10.25 cm; right ankle 10.50 cm, left ankle 9.75 cm), along with reduced sensation in the left foot. He also reports generalized weakness and difficulty with ambulation and toileting. Nutritionally, the patient is dependent on tube feeding for support, with orders for 2.0 calorie HN formula at 4-5 cans daily; however, intake has been reduced to 2-3 cans per day due to intolerance as reported by the spouse. Water flushes of 120 mL twice daily are being administered with consideration of recurrent pleural effusions. The patient remains at high risk for malnutrition and dehydration. Functionally, the patient demonstrates significant decline from prior level of function. Per caregiver report, he was independently ambulatory with a single-point cane approximately two months ago; currently, he requires assistance for all basic activities of daily living, bed mobility, transfers, and ambulation. He ambulates short distances with a cane and one-person assist but exhibits unsteady gait, decreased lower extremity strength, impaired balance, and decreased endurance. He experiences shortness of breath with minimal exertion, particularly when negotiating stairs. The home environment includes three steps at the entrance and 16 steps to the second-floor bedroom, which pose a considerable challenge; the patient requires substantial assistance for stair navigation. He is considered homebound due to significant functional limitations, generalized weakness, and high fall risk, requiring human assistance and an assistive device to leave the home safely. Skilled nursing services were initiated with a frequency of 1 visit per week for 2 weeks, followed by 1 visit per week for 5 weeks, to provide ongoing assessment, medication management, and education. All medications, including dosing, frequency, and potential side effects, were reviewed with the patient and spouse. Education was initiated regarding care and management of PleurX catheters, signs and symptoms requiring skilled nursing or physician notification, and general disease management. The spouse, who serves as the primary caregiver with 24-hour support, was receptive to all teaching provided. Rehabilitation services have been recommended, including physical and occupational therapy evaluations, with occupational therapy to further assess the need for home health aide support. Physical therapy is planned to address deficits in strength, balance, gait, transfers, and safety awareness, with the goal of improving functional mobility and reducing fall risk. A home exercise program was initiated, including supine therapeutic exercises such as ankle pumps, quadriceps sets, gluteal sets, heel slides, straight leg raises, and hip abduction, with instructions to perform twice daily. The patient and caregiver were educated on the importance of frequent repositioning, including hourly position changes, sidelying in bed, and sitting upright in a chair when tolerated, as well as initiating a gradual ambulation program with short, assisted walks every 1-2 hours to improve circulation and prevent complications of immobility. Overall, the patient presents with significant medical complexity and functional impairment requiring interdisciplinary home health services. The plan of care includes continued skilled nursing for monitoring and education, as well as physical and occupational therapy to address mobility and functional deficits, prevent further decline, and promote safety and quality of life in the home setting.
 Date of Order 04/30/2026 Orders <span

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/30/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Uchemadu Nwaononiwu
7670 Quarterfield Road
Glen Burnie, MD 21061
PHONE: FAX: NPI: 1770710451

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 : 04/22/2026

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;">Physician Face-to-Face Date: 04/22/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Malignant neoplasm of esophagus unspecified 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 OT Eval Notes: PT Eval Notes: Physician Nwaononiwu, Uchemadu

SN Careplans

SN WK1: 1 (04/30/26-05/02/26) ,WK2: 2 (05/03/26-05/09/26) ,WK3: 2 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/23/26) ,WK5: 1 (05/24/26-05/30/26) ,WK6: 1 (05/31/26-06/06/26) ,WK7: 1 (06/07/26-06/13/26) ,WK8: 1 (06/14/26-06/20/26)

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: 4. Multiple emergency department visits (2 or more) in the past 6 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 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 Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, meal preparation, lung sounds not clear, M1033 - Exhaustion, M1400 - Dyspnea, nausea/vomiting, limited strength, limited endurance, balance deficit, Pain Effect on Sleep, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises, administer tube feeding: PATIENT TO RECEIVE 2-3 CANS OF 2.0 CAL HN A DAY. 120 CC H20 FLUSHES DAILY

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, * 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

SN Goals

PATIENT-STATED GOAL: TO GET STRONGER

GOALS
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
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

04/30/2026

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7. Provider's Name, Address and Telephone Number
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1487113239

PT WK2: 1 (05/03/26-05/09/26) ,WK7: 1 (06/07/26-06/13/26) ,WK8: 1 (06/14/26-06/20/26) ,WK9: 1 (06/21/26-06/27/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea, Pain Interference with Therapy activities, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170S1 - Wheel 150 feet, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, 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, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: cough/deep breathing exercises, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., gait training on uneven surfaces, gait training/stair training, transfers training

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, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, Car Transfer - 05. Setup or clean-up assistance

PATIENT-STATED GOAL: To be able to do things by myself, to improve strength

GOALS
Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

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

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

Car Transfer - 05. Setup or clean-up assistance

OT Careplans

OT WK2: 1 (05/03/26-05/09/26) ,WK3: 1 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/23/26) ,WK5: 1 (05/24/26-05/30/26) ,WK6: 1 (05/31/26-06/06/26) ,WK7: 1 (06/07/26-06/13/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating

PROCEDURES: Therapeutic exercise : exe during the visit, Medication review : med updates, Endurance training : activity tolerance, cough/deep breathing exercises, incentive spirometer, home exercise program, equipment training, work simplification/energy conservation

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, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: to be able to perform ALDs by himself

GOALS
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

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 04. Supervision or touching assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

Signature of Physician:

Date

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

Date
04/30/2026