Home Health Certification and Plan of Care

Order ID: 1150/20832

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
11294094	07/24/2026	From: 07/24/2026 To: 09/21/2026	28302	217058

6. Patient's Name and Address

Solange Pierre Louis
18 Greenshire Lane,
OWINGS MILLS, MD 21117-
410-419-0655

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 12/20/1936 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
K92.2	Gastrointestinal hemorrhage unspecified	07/24/26

13. ICD	Other Pertinent Diagnoses	Date
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	07/24/26
I50.32	Chronic diastolic (congestive) heart failure	07/24/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	07/24/26
N18.4	Chronic kidney disease stage 4 (severe)	07/24/26
I69.354	Hemiplga following cerebral infrc affecting left nondom side	07/24/26
F03.90	Unsp dementia unsp severity without beh/psych/mood/anx	07/24/26
E78.5	Hyperlipidemia unspecified	07/24/26
K59.00	Constipation unspecified	07/24/26
R33.9	Retention of urine unspecified	07/24/26
Z79.82	Long term (current) use of aspirin	07/24/26
Z79.4	Long term (current) use of insulin	07/24/26
Z46.6	Encounter for fitting and adjustment of urinary device	07/24/26

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

PRECOSE 100 mg by mouth 3 times daily with meals
NORVASC 10 mg by mouth 1 time daily
ASPIRIN 81 mg by mouth 1 time daily
LIPITOR 40 mg by mouth nightly
APRESOLINE 25 mg by mouth 3 times daily
Toprol-Xl - Metoprolol Succinate 50 mg by mouth 1 time daily
LASIX 20 mg by mouth 1 time daily As needed for water retention
TYLENOL 500 mg- 2 tablets by mouth every 6 hours PRN
Protonix - Pantoprazole Sodium eq 40 mg base by mouth once a day
ROCALTROL 0.25 mcg by mouth three times per week
ALBUTEROL 108 (90 BASE) mcg/act IN aerosol solution / 2 puffs inhalant every 6 hours PRN
HUMALOG 10 Units subcutaneous 2 times daily before meals
Humulin N - Insulin Susp Isophane Recombinant Human 26 Units subcutaneous nightly
Mounjaro 10 mg subcutaneous every 7 days

14. DME and Supplies:

wheelchair, hoyer lift, diabetic supplies

15. Safety Measures:

bathroom safety, hand rails, wheelchair precautions, no bp left arm, medication safety, diabetic precautions, fall precautions

16. Nutrition:

diabetic

17. Allergies:

flu vaccine losartan penicillin

18.A. Functional Limitations

Contracture, Paralysis, Bowel/Bladder Incontinence, Hearing

18.B. Activities Permitted

Complete Bedrest

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., 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, HISTORY OF DEPRESSION: No

20. Prognosis: poor

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 Gastrointestinal hemorrhage 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 an 89-year-old female admitted to home health services following hospitalization at BWMC for an upper gastrointestinal (GI) bleed and urinary tract infection (UTI). Her past medical history is significant for dementia, chronic kidney disease (CKD) stage IV, hypertension, heart failure with preserved ejection fraction (HFpEF), type 2 diabetes mellitus, hyperlipidemia, prior cerebrovascular accident (CVA) with chronic left-sided hemiparesis, dysarthria, dysphagia, palliative care status, and multiple additional comorbidities. The patient has been bedbound for over one year and is dependent on family caregivers for all activities of daily living (ADLs), mobility, transfers, and personal care. She resides with her daughter, who serves as her primary caregiver and provided translation during the visit, as the patient's primary language is French Creole and she speaks limited English. Upon arrival for the initial skilled nursing visit, the patient was observed resting in a hospital bed located in the living room. She was minimally verbal throughout the visit but was able to follow simple commands, such as taking deep breaths, and correctly stated her name and date of birth in her primary language. The patient denied pain. Her daughter reported that the patient's last bowel movement occurred the previous day; however, the patient is experiencing constipation. A comprehensive assessment was completed, including medication reconciliation with the daughter and completion of the home health admission process. Vital signs were stable, with blood pressure of 122/64 mmHg in the right arm, temperature of 97.5F, pulse of 61 beats per minute via the right radial artery, and oxygen saturation of 96% on room air. Respirations were even and unlabored, with lungs clear to auscultation bilaterally. The patient measured 5 feet 9 inches in height and weighed 180 pounds. The patient has chronic left-sided weakness secondary to a previous stroke and remains non-ambulatory, requiring total assistance for bed mobility, repositioning, transfers, and all ADLs. She has an indwelling Foley catheter that was last changed during her hospitalization on 07/15/2026 and is managed by Urology with routine catheter changes every four weeks. The patient's skin was noted to be dry and intact, with no evidence of current pressure injuries or skin breakdown as reported by her daughter. Ongoing monitoring is warranted due to the patient's immobility and elevated risk for pressure injuries. Skilled nursing education was provided to the caregiver regarding medication adherence, Foley catheter care and monitoring for signs and symptoms of urinary tract infection, bowel management and constipation prevention, pressure injury prevention through routine repositioning and skin assessment, adequate hydration and nutrition, infection prevention, and recognition of symptoms requiring prompt physician notification or emergency evaluation. The caregiver demonstrated understanding of the education provided and remains competent in providing the patient's daily care. A skilled home health physical therapy evaluation was completed following the recent hospitalization. The patient presents with chronic bedbound status, generalized weakness, severe functional mobility impairment, cognitive deficits, and complete dependence for all mobility and transfers. At the time of evaluation, the patient was functioning at her reported baseline level with no new decline requiring skilled physical therapy intervention. The caregiver demonstrated appropriate knowledge and competency in safe positioning, transfers, pressure relief techniques, and daily care. Therefore, the patient will not be admitted to the skilled physical therapy caseload. Recommendations include continued 24-hour caregiver assistance, ongoing pressure injury prevention measures, and follow-up with the physician as indicated. A skilled occupational therapy evaluation determined that, despite the patient's long-standing dependence for all care, she would benefit from skilled occupational therapy services to improve bed mobility techniques, optimize positioning, and address left upper extremity positioning to prevent contractures, maintain joint integrity, maximize comfort, and reduce caregiver burden. Continued skilled home health services remain medically necessary to monitor the patient's complex medical conditions, provide disease management, reinforce caregiver education, and promote safety while minimizing the risk of complications and rehospitalization.
 Date of Order 07/24/2026 Orders Physician Face-to-Face Date: 07/19/2026 <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/24/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Raymond Dormevil
7141 Security Blvd
Baltimore, MD 21244
PHONE: 443-663-6000 FAX: 14436636215 NPI: 1245627892

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 : 07/19/2026

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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14px;">Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Gastrointestinal hemorrhage 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 Dormevil, Raymond

SN Careplans

SN WK1: 1 (07/24/26-07/25/26) ,WK2: 1 (07/26/26-08/01/26) ,WK3: 1 (08/02/26-08/08/26) ,WK4: 1 (08/09/26-08/15/26) ,WK5: 1 (08/16/26-08/22/26)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 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

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/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: M1745 - Behavioral Issues, M1700 - Cognition, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, M1400 - Dyspnea, lung sounds not clear, abnormal BS < 70/140 > mg/dL, constipation, M1610 - Urinary Catheter, M1600 - UTI, muscle weakness, limited range of motion, limited strength, poor muscle tone, B1000 - Vision Deficit, weak hand grips, obesity

PROCEDURES: cough/deep breathing exercises, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor, catheter change, care & irrigation: LAst changed at BWMC 7/15/2026 Indwelling Urinary Catheter changes every 4 weeks managed by Urology, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange resources for vision-impaired

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 keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * urinary catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, 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, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: Family "I want assistance with caring for my mom."

GOALS
patient/caregiver recalls
* urinary catheter management including how to flush catheter
* change and wash drainage bags
* prevent infection including proper handwashing
* positioning of catheter
* 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
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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 is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

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

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/24/2026

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PT Careplans

PT WK1: 5 (07/24/26-07/25/26) ,WK2: 5 (07/26/26-08/01/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170A1 - Roll left & Right, GG0170B1 - Sit to Lying, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car Transfer, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170S1 - Wheel 150 feet, GG0170E1 - Chair to Bed to Chair

PROCEDURES: wheelchair training, home exercise program: PT eval only, transfers training

TEACH PATIENT/CAREGIVER: Roll left & Right - 01. Dependent, Sit to Lying - 01. Dependent, Sit to Stand - 01. Dependent, Chair to Bed to Chair - 01. Dependent, Toilet Transfer - 01. Dependent, Car Transfer - 01. Dependent, Wheel 50 ft w 2 Turns - 01. Dependent, Wheel 150 feet - 01. Dependent

PT Goals

PATIENT-STATED GOAL: PT eval only

GOALS
Roll left & Right - 01. Dependent

Sit to Lying - 01. Dependent

Sit to Stand - 01. Dependent

Chair to Bed to Chair - 01. Dependent

Toilet Transfer - 01. Dependent

Car Transfer - 01. Dependent

Wheel 50 ft w 2 Turns - 01. Dependent

Wheel 150 feet - 01. Dependent

OT Careplans

OT WK1: 1 (07/24/26-07/25/26) ,WK3: 1 (08/02/26-08/08/26) ,WK5: 1 (08/16/26-08/22/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, 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: cough/deep breathing exercises, home exercise program: Caregiver traininng for PROM ex's to LUE to prevent contractures and RUE AROM to maintain range, equipment 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, Roll left & Right - 01. Dependent, Sit to Lying - 01. Dependent, Sit to Stand - 01. Dependent, Chair to Bed to Chair - 01. Dependent, Toilet Transfer - 01. Dependent, Car Transfer - 01. Dependent, Wheel 50 ft w 2 Turns - 01. Dependent, Wheel 150 feet - 01. Dependent, Oral Hygiene - 01. Dependent, Toileting Hygiene - 01. Dependent, Shower/Bathe Self - 01. Dependent, Upper Body Dressing - 01. Dependent, Lower Body Dressing - 01. Dependent, Don/Doff Footwear - 01. Dependent, Eating - 05. Setup or clean-up assistance, PROM to LUE and AROM to RUE. LUE positioning

OT Goals

PATIENT-STATED GOAL: ccaregiver asked to assist in bed mobility and LUE positioning and ROM to prevent contructures

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

Roll left & Right - 01. Dependent

Sit to Lying - 01. Dependent

Sit to Stand - 01. Dependent

Chair to Bed to Chair - 01. Dependent

Toilet Transfer - 01. Dependent

Car Transfer - 01. Dependent

Wheel 50 ft w 2 Turns - 01. Dependent

Wheel 150 feet - 01. Dependent

Oral Hygiene - 01. Dependent

Toileting Hygiene - 01. Dependent

Shower/Bathe Self - 01. Dependent

Upper Body Dressing - 01. Dependent

Lower Body Dressing - 01. Dependent

Don/Doff Footwear - 01. Dependent

Eating - 05. Setup or clean-up assistance

PROM to LUE and AROM to RUE. LUE positioning

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/24/2026