Home Health Certification and Plan of Care

Order ID: 1150/12223

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6ff9h75dx11	08/30/2025	From: 08/30/2025 To: 10/28/2025	16935	217058

6. Patient's Name and Address
Brenda Clark
13110 Patuxent Rd,
MIDDLE RIVER, MD 21220-
443-827-5112

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 09/21/1961 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I69.351	Hemiplga following cerebral infrc aff right dominant side	08/30/25

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	08/30/25
E11.65	Type 2 diabetes mellitus with hyperglycemia	08/30/25
M54.2	Cervicalgia (M54.2)	08/30/25
M54.50	Low back pain unspecified	08/30/25
G89.29	Other chronic pain	08/30/25
F33.3	Major depressv disorder recurrent severe w psych symptoms	08/30/25
R32.	Unspecified urinary incontinence	08/30/25
R00.1	Bradycardia unspecified	08/30/25
Z79.82	Long term (current) use of aspirin	08/30/25
Z79.51	Long term (current) use of inhaled steroids	08/30/25
Z72.0	Tobacco use	08/30/25
Z79.4	Long term (current) use of insulin	08/30/25
Z91.81	History of falling	08/30/25

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

Lantus - Insulin Glargine Recombinant 100 units/ml 33 units subcutaneous at bedtime DM
Metformin Er - Metformin Hydrochloride 500MG; 2 TABS by mouth twice a day DM
Lexapro - Escitalopram Oxalate eq 20 mg base 20MG; 1 TAB by mouth once a day DEPRESSION
Gabapentin - Gabapentin 100 mg 100MG; 1CAP by mouth every 8 hours FOR PAIN
Olanzapine - Olanzapine 2.5 mg 2.5MG; 1TAB by mouth once a day AGITATION
Depakote - Divalproex Sodium eq 250 mg valproic acid 250MG; 1 TAB by mouth twice a day AGITATION/MOOD
Amlodipine Besylate - Amlodipine Besylate eq 5 mg base 5 MG , Give 1 tablet by mouth once a day Give 1 tablet by mouth one time a day for htn hold SBP<110 pulse <60
Lisinopril - Lisinopril 40 mg 40 MG , Give 1 tablet by mouth once a day Give 1 tablet by mouth one time a day for HTN hold SBP less then 110
Melatonin - Melatonin 10 MG , Give 1 tablet by mouth at bedtime Give 1 tablet orally at bedtime for insomnia
Atorvastatin - Atorvastatin Calcium 80mg, take 1 tablet by mouth at bedtime Cholesterol

14. DME and Supplies:
None of the above

15. Safety Measures:
standard precautions, diabetic precautions, fall precautions, medication safety, ambulates with assistance, transfer with assist

16. Nutrition:
cardiac diet, diabetic

17. Allergies:
iodine

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, 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, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

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 Hemiplegia following cerebral infarction affecting right dominant side, 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 recently admitted individual with a significant past medical history including poorly controlled Type 2 diabetes mellitus (DM2), hypertension, depression, chronic back pain, failure to thrive (FTT), and a previous cerebrovascular accident (CVA) resulting in right-sided hemiplegia. At the time of assessment, the patient was alert and oriented to person and place (AOx2) but forgetful and with a flat affect. The patient denies pain during the visit, although moderate right shoulder pain was noted in other documentation. Lung sounds were clear but diminished throughout. The patient has no assistive device currently but presents with a dysfunctional gait and would benefit from one-physical therapy evaluation is pending. Appetite is good, and the patient had a bowel movement on the day of the visit. Skilled nursing visits are scheduled to focus on disease process teaching, medication and diet education, and ongoing assessment. The patient currently lacks a glucometer and has not received all prescribed medications from the pharmacy. The home environment is cluttered and poorly maintained. The patient lives with a son who serves as the primary caregiver. The caregiver was instructed to immediately contact the pharmacy to refill the patient's blood pressure medication, which was missing at the time of the visit. The patient is also currently smoking and not using a nicotine patch. The sister is involved in managing the patient's care and was receptive to the initial diabetic teaching but would benefit from additional instruction. Skilled nursing reviewed all current medications and began diabetic management education. The patient's elevated blood pressure, lack of access to medications, cognitive limitations, and unsafe home environment indicate the need for continued skilled nursing and therapy services to address safety, medication compliance, functional mobility, and disease management.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 08/30/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 08/19/2025
 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Hemiplegia following cerebral infarction affecting right dominant side
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval Notes:<o:p></o:p> Physician: Wright, Ernestine

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 08/30/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Ernestine Wright
301 Saint Paul Place
Baltimore, MD 21202
PHONE: 410-332-4291 FAX: 14103324421 NPI: 1306896006

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 : 08/19/2025

27. Attending Physician's Signature and Date Signed **09/22/2025** 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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SN WK1: 1 (08/30/25-08/30/25) ,WK3: 2 (09/07/25-09/13/25) ,WK4: 1 (09/14/25-09/20/25) ,WK5: 1 (09/21/25-09/27/25) ,WK6: 1 (09/28/25-10/04/25) ,WK7: 1 (10/05/25-10/11/25) ,WK8: 1 (10/12/25-10/18/25) ,WK9: 1 (10/19/25-10/25/25)

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: 5. Decline in mental, emotional, or behavioral status 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; 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: M1700 - Cognition, M1745 - Behavioral Issues, D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor: NEED A GLUCOMETER

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * 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 optimize mental status with cognition therapy home safety optimize mobility with active and passive range of motion therapeutic exercises diet and fluids to optimize peripheral circulation, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver, 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, * 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, * 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-STATED GOAL: TO MANAGE HER HEALTH ISSUES

GOALS
patient/caregiver recalls
* how to optimize mental status with cognition therapy
* home safety
* optimize mobility with active and passive range of motion therapeutic exercises
* diet and fluids to optimize peripheral circulation
* recalls related medication(s) purpose, schedule

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

patient/caregiver recalls
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

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/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 keep home safe for patient with dementia
* coping strategies for the caregiver
* 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
* 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 WK3: 1 (09/07/25-09/13/25) ,WK4: 2 (09/14/25-09/20/25) ,WK5: 2 (09/21/25-09/27/25) ,WK6: 2 (09/28/25-10/04/25) ,WK7: 1 (10/05/25-10/11/25) ,WK8: 1 (10/12/25-10/18/25) ,WK9: 1 (10/19/25-10/25/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object

PROCEDURES: Medication Review : The medication was reviewed with the patient , Home exercises: Long arc , slr, le abd/add, marching and mini squats --all 10x2 reps , cough/deep breathing exercises, incentive spirometer, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition

PT Goals

PATIENT-STATED GOAL: To get stronger and walk straight

GOALS
Chair to Bed to Chair - 06. Independent

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

Signature of Physician:

Date

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

Date
08/30/2025

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including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car 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	* recalls related medication(s) purpose, schedule Sit to Stand - 06. Independent Car 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 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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	08/30/2025