Home Health Certification and Plan of Care

Order ID: 1150/13758

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
9FR1NY8RN22	11/05/2025	From: 11/05/2025 To: 01/03/2026	18817	217058

6. Patient's Name and Address

Norman Thomas
5519 Gerland Ave,
BALTIMORE, MD 21206-
443-858-1872

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 02/13/1957 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I69.318	Other symptoms and signs w cogn fnctns fol cerebral infrc	11/05/25

13. ICD	Other Pertinent Diagnoses	Date
F01.50	Vascular dementia unsp severity without beh/psych/mood/anx	11/05/25
I10.	Essential (primary) hypertension	11/05/25
E11.9	Type 2 diabetes mellitus without complications	11/05/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	11/05/25
E78.2	Mixed hyperlipidemia	11/05/25
B20.	Human immunodeficiency virus [HIV] disease	11/05/25
Z79.4	Long term (current) use of insulin	11/05/25
Z79.82	Long term (current) use of aspirin	11/05/25

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

Aspirin - Aspirin 81 MG Oral Tablet, Take 1 tablet by mouth once a day for prophylaxis
(BictegravirEmtricitabine-Tenofovir Alafenamide Fumarate 30-120-15 MG Oral Tablet, Take 1 tablet by mouth once a day for HIV Resident to bring his own medication from home
Metformin Hcl - Metformin Hydrochloride 500 MG Oral Tablet, Take 1 tablet by mouth twice a day a day for DM2
Atorvastatin - Atorvastatin Calcium 40 MG Oral Tablet, Take 1 tablet by mouth at bedtime for HLD
Amlodipine Besylate - Amlodipine Besylate eq 10 mg base 10 MG Oral Tablet,Take 1 tablet by mouth once a day for hypertension Hold if SBP is less than 110 or pulse is less than 60
Glipizide - Glipizide 10 mg 10 MG Oral Tablet, Take 1 tablet by mouth once a day a day for diabetes
Metoprolol Tartrate - Metoprolol Tartrate 50 mg 50 MG Oral Tablet, Take 1 tablet by mouth twice a day for Hypertension Hold if SBP is less than 110 or pulse is less than 60
Hydralazine And Hydrochlorothiazide - Hydralazine Hydrochloride: Hydrochlorothiazide 10 MG Oral Tablet , Take 1 tablet by mouth three times a day for HTN
Entered
Losartan Potassium - Losartan Potassium 100 mg 100 MG Oral Tablet, take 1 tablet by mouth once a day for hypertension Hold if SBP is less than 110 or pulse is less than 60

14. DME and Supplies:

hospital bed, wheelchair, commode, walker, cane

15. Safety Measures:

diabetic precautions, ambulates with device, transfer with assist, bedrails up while in bed, ambulates with assistance, wheelchair precautions, , , activity supervision, walker precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Bowel/Bladder Incontinence, Speech, Endurance, Ambulation

18.B. Activities Permitted

Exercises Prescribed, Wheelchair, Walker, Cane, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, 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: 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 Other Symptoms And Signs Involving Cognitive Functions Following Cerebral Infarction, 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 68-year-old male who is alert and oriented 3, residing in a single-family home with a roommate who assists with weekly medication setup and occasional support as needed. His daughter, Ashley, who lives in Baltimore, serves as his primary caregiver through frequent phone involvement and occasional <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh>. The patient receives caregiver assistance daily from 0700-1000 hours. His past medical history is significant for hypertension, coronary artery disease, multiple cerebrovascular accidents (CVA), vascular dementia without behavioral disturbance, HIV disease, hyperlipidemia, and type 2 diabetes mellitus without complications. The patient was recently hospitalized due to generalized weakness and hypotension with associated bilateral lower extremity weakness, followed by a rehabilitation stay at Autumn Lake prior to returning home. He also reports a fall prior to hospitalization, though no injuries were sustained. Upon current <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient demonstrates reduced standing balance, limited activity tolerance, and bilateral upper and lower extremity weakness, contributing to decreased independence with activities of daily living (ADLs), functional transfers, and mobility. He uses a wheelchair, walker, and cane for mobility and requires assistance with most ADLs. Transfers from recliner to standing position require minimal assistance, while bed and bedside commode transfers are completed with contact guard assistance and verbal cues. Bed mobility is performed with supervision and prompting. Ambulation is limited to short distances (approximately 25 feet 2) on indoor surfaces with a rolling walker and contact guard assistance. Outdoor mobility and car transfers were not assessed during this visit. The home is equipped with a ramp for porch access. The patient is considered homebound due to the considerable effort required to leave his residence, supported by a Tinetti Balance <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">Assessment</mh> score of 9/28, indicating a high risk for falls. Therapeutic exercise included 10 repetitions each of supine hip flexion, bridging, straight leg raises, hip abduction, seated knee extensions, and ankle pumps, which were tolerated without distress. During the session, a household boarder residing in the basement was present as an observer. Skilled physical therapy is indicated to address strength deficits, improve functional mobility, and enhance safety and balance to reduce fall risk and promote independence in daily activities. Additionally, skilled occupational therapy services are recommended to target deficits in upper extremity strength, standing tolerance, and activity endurance that are limiting self-care

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 11/05/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Stefan David
3900 Loch Raven Blvd Blg 2
Baltimore, MD 21218
PHONE: 4106057620 FAX: 14102098418 NPI: 1467745067

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 : 10/28/2025

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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performance and transfer safety. Patient education was provided regarding the importance of regular exercise, safe transfer techniques, fall prevention strategies, and proper use of assistive devices. The patient verbalized understanding and demonstrated receptiveness to the teaching. The plan of care includes ongoing skilled home health physical and occupational therapy to restore strength, improve endurance and functional mobility, and maximize safety and independence within the home environment.
 Date of Order 11/05/2025 Orders Physician Face-to-Face Date: 10/28/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Other Symptoms And Signs Involving Cognitive Functions Following Cerebral Infarction 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: Created 1 - SOC - SN by admission PT Eval Notes: OT Eval Notes:
 Physician David, Stefan

SN Careplans

SN WK1: 1 (11/05/25-11/08/25) ,WK3: 1 (11/16/25-11/22/25) ,WK5: 1 (11/30/25-12/06/25) ,WK7: 1 (12/14/25-12/20/25)

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: 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; 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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M2102d - Caregiver Performs Treatment, D0700 - Social Isolation, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, M1620 - Bowel Incontinence, muscle weakness, limited range of motion, limited strength, limited endurance, balance deficit, weak hand grips, B1000 - Vision Deficit, impaired speech, obesity

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange resources for vision-impaired

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 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, * bowel incontinence management including dietary changes bowel training skin care, 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, * strategies to increase socialization, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: "To get stronger"

GOALS
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

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 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
* bowel incontinence management including dietary changes
* bowel training
* skin care
* 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

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK2: 1 (11/09/25-11/15/25) ,WK3: 2 (11/16/25-11/22/25) ,WK4: 1 (11/23/25-11/29/25), WK5: 1 (11/30/25-12/06/25) ,WK6: 1 (12/07/25-12/13/25) ,WK7: 1 (12/14/25-12/20/25) ,WK8: 1 (12/21/25-12/26/25)

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: Home exercise program : Sitting knee extension, ankle pumps. Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee

PT Goals

PATIENT-STATED GOAL: Be able to get up from recliner by myself

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

Sit to Stand - 04. Supervision or touching assistance

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/05/2025

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flexion, hip abduction, hip extension, plantarflexion, squats , Bed mobility training , Bed mobility training , Family training , 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, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Toilet Transfer - 05. Setup or clean-up assistance

Car Transfer - 04. Supervision or touching assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

OT Careplans

OT WK3: 1 (11/16/25-11/22/25) ,WK4: 1 (11/23/25-11/29/25) ,WK5: 1 (11/30/25-12/06/25) ,WK6: 1 (12/07/25-12/13/25) ,WK7: 1 (12/14/25-12/20/25) ,WK8: 1 (12/21/25-12/26/25)

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

PROCEDURES: equipment training, work simplification/energy conservation, transfers training, assist with bathing, assist with lower body dressing, assist with upper body dressing, therapeutic exercises

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

OT Goals

PATIENT-STATED GOAL: I want to drive

GOALS
Shower/Bathe Self - 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

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/05/2025