

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	
9FR1NY8RN22		11/05/2025		From: 11/05/2025 To: 01/03/2026	
4. Medical Record No.		5. Provider No.		18817	
217058					
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Norman Thomas 5519 Gerland Ave, BALTIMORE, MD 21206- 443-858-1872			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
02/13/1957			Male		
11. ICD			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
Principal Diagnosis			Aspirin - Aspirin 81 MG Oral Tablet, Take 1 tablet by mouth once a day for prophylaxis		
169.318 Other symptoms and signs w cogn fnctns fol cerebral infrc			(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		
13. ICD			Metformin Hcl - Metformin Hydrochloride 500 MG Oral Tablet, Take 1 tablet by mouth twice a day a day for DM2		
Other Pertinent Diagnoses			Atorvastatin - Atorvastatin Calcium 40 MG Oral Tablet, Take 1 tablet by mouth at bedtime for HLD		
F01.50 Vascular dementia unsp severity without beh/psych/mood/anx			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		
I10. Essential (primary) hypertension			Glipizide - Glipizide 10 mg 10 MG Oral Tablet, Take 1 tablet by mouth once a day a day for diabetes		
E11.9 Type 2 diabetes mellitus without complications			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		
I25.10 Athscl heart disease of native coronary artery w/o ang pctrs			Hydralazine And Hydrochlorothiazide - Hydralazine Hydrochloride: Hydrochlorothiazide 10 MG Oral Tablet , Take 1 tablet by mouth three times a day for HTN		
E78.2 Mixed hyperlipidemia			Entered		
B20. Human immunodeficiency virus [HIV] disease			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		
Z79.4 Long term (current) use of insulin					
Z79.82 Long term (current) use of aspirin					
14. DME and Supplies:			15. Safety Measures:		
hospital bed, wheelchair, commode, walker, cane			diabetic precautions, ambulates with device, transfer with assist, bedrails up while in bed, ambulates with assistance, wheelchair precautions, , , activity supervision, walker precautions		
16. Nutrition:			17. Allergies:		
Z. NO PHYSICIAN-ORDERED DIET			no known allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
Bowel/Bladder Incontinence, Speech, Endurance, Ambulation			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:			22.B.Discharge Plans		
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.			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:			<div>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:			25. Date HHA Received Signed POT		
Electronically Signed by Messick, Charles RN on 11/05/2025					
24. Physician's Name and Address			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.		
Stefan David			F2F date : 10/28/2025		
3900 Loch Raven Blvd Blg 2					
Baltimore, MD 21218					
PHONE: 4106057620 FAX: 14102098418 NPI: 1467745067					
27. Attending Physician's Signature and Date Signed			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.		
11/12/2025 Date of physician last face-to-face			PAGE 1 of 3		

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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.</div><div> </div><div> </div><div>Date of Order</div><div>11/05/2025</div><div>Orders</div><div>Physician Face-to-Face Date: 10/28/2025</div><div>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</div><div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div> </div><div> </div><div>1 - SOC - SN Notes: Created 1 - SOC - SN by admission</div><div><div>PT Eval Notes:</div><div>OT Eval Notes:</div><div>Physician</div><div>David, Stefan</div>					
SN Careplans				SN Goals	
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)				PATIENT-STATED GOAL: "To get stronger"	
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				GOALS	
CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance				patient/caregiver recalls	
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				* lifestyle modifications to manage cardiac condition including symptom management	
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				* diet changes	
Advance Directive:Living Will				* regular exercise	
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				* getting enough sleep	
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				* recalls related medication(s) purpose, schedule	
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				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	
				* 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 Goals	
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)				PATIENT-STATED GOAL: Be able to get up from recliner by myself	
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				GOALS	
PROCEDURES: Home exercise program : Sitting knee extension, ankle pumps. Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee				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	
				PAGE 2 of 3	
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			Chair to Bed to Chair - 04. Supervision or touching assistance		
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			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 Goals		
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)			PATIENT-STATED GOAL: I want to drive		
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			GOALS		
PROCEDURES: equipment training, work simplification/energy conservation, transfers training, assist with bathing, assist with lower body dressing, assist with upper body dressing, therapeutic exercises			Shower/Bathe Self - 05. Setup or clean-up assistance		
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			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
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