Home Health Certification and Plan of Care

Order ID: 1150/16351

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2RU2R93AY02	02/17/2026	From: 02/17/2026 To: 04/17/2026	22405	217058

6. Patient's Name and Address
Rhoda Spencer
3204 Hayward Ave,
Baltimore, MD 21215-
4438418720

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 01/19/1957 | **9.Sex** Female

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

COLACE 1 capsule Oral every 12 hours as needed for Bowel regimen
LABETALOL 1 tablet Oral two times a day for HTN
MELATONIN 1 tablet Oral every 24 hours as needed for SLEEP AT HS PRN
SENOKOT 2 tablet Oral two times a day as needed for BOWEL REGIMEN HOLD FOR LOOSE STOOL
Guaifenesin - Guaifenesin 400mg per tab by mouth every 4 hours Take 1 tab ever6 4 hours for mucus relief
Nifedipine - Nifedipine 30 mg 30 mg by mouth once a day Take 1 tab daily for blood pressure control.
Lipitor - Atorvastatin Calcium eq 40 mg base 40mg by mouth at bedtime Take 1 tab nightly for cholesterol control
Metformin - Metformin Hydrochloride 500mg tabs by mouth twice a day Take 1 tab twice a day for diabetes

11. ICD	Principal Diagnosis	Date
I69.354	Hemiplga following cerebral infrc affecting left nondom side	02/17/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	02/17/26
E11.9	Type 2 diabetes mellitus without complications	02/17/26
E78.5	Hyperlipidemia unspecified	02/17/26
F43.21	Adjustment disorder with depressed mood	02/17/26
F06.8	Oth mental disorders due to known physiological condition	02/17/26
G47.00	Insomnia unspecified	02/17/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	02/17/26
Z87.440	Personal history of urinary (tract) infections	02/17/26
Z91.81	History of falling	02/17/26

14. DME and Supplies:
wheelchair, rolling walker, hand held shower, diabetic supplies, bath bench, commode, grab bars, reacher, walker, cane, 4 wheeled walker, hemi walker

15. Safety Measures:
walker precautions, smoke detectors , , , diabetic precautions, ambulates with device, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, supervision at all times, wheelchair precautions, , hand rails, bathroom safety, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Up As Tolerated, Walker, 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!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

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 And Hemiparesis Following Cerebral Infarction Affecting Left Non-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:
Mrs. Spencer is a 68-year-old female admitted to home health services following recent hospitalization for a fall and urinary tract infection. It is noted that she experienced four falls prior to hospitalization. Her past medical history is significant for a cerebrovascular accident (CVA) in 2023 resulting in left hemiparesis/hemiplegia, cerebral infarction, hypertension, hyperlipidemia, and type II diabetes mellitus. She resides in a rowhome across from Pimlico racetrack with her significant other, who serves as her primary live-in caregiver. She also receives additional support from her sister. The patient remains on the first level of the home to avoid stair negotiation. The home is equipped with necessary durable medical equipment, including a walker, hemi-walker, wheelchair for longer distances, bedside commode for nighttime use, shower transfer bench, and a left-hand brace with palm protector for support and contracture prevention following CVA. There are no pets in the home. All medications are present in the home. The patient is designated as full code with a MOLST on file. The patient and caregiver have expressed interest in home health aide services to assist with personal care needs. Prior to hospitalization, the patient was ambulating with supervision using a hemi-walker and utilized a wheelchair for longer distances. On evaluation, she continues to ambulate with a hemi-walker under supervision. She demonstrates residual left-sided weakness consistent with prior CVA, contributing to impaired balance, decreased strength, and increased fall risk. Her significant other assists with activities of daily living (ADLs), including bathing and dressing, since her CVA in 2023. She uses a shower transfer bench for bathing and a bedside commode at night for toileting. The caregiver prepares all meals and provides 24/7 care, while the patient's sister assists with medication pickup and grocery shopping. Physical therapy evaluation indicates that the patient would benefit from skilled intervention to improve strength, balance, safety awareness, and overall functional mobility in order to return to her prior level of function and reduce fall risk. Education was provided to both the patient and caregiver regarding the importance of increasing daily ambulation, including adding one additional supervised walking round per day to improve endurance and mobility. Occupational therapy evaluation further identified the need for ADL retraining, therapeutic exercise, home exercise program development, contracture management for the affected left upper extremity, functional mobility training, safety training, and fall prevention strategies. OT services are recommended at a frequency of once weekly for six weeks to address these deficits. Given her recent falls, residual hemiparesis, impaired balance, and need for assistive devices and supervision with ambulation and ADLs, the patient is considered homebound due to the considerable and taxing effort required to leave the home safely. The plan of care includes skilled physical and occupational therapy to address strength, mobility, ADL performance, fall prevention, and caregiver education, with the goal of maximizing independence, improving safety within the home, and preventing rehospitalization.
 Date of Order 02/17/2026 Orders Physician Face-to-Face Date: 02/04/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Hemiplegia And Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side Homebound Status per Certifying Physician: patient requires another person or medical equipment such as

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 02/17/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Fei Zhao
900 S. Caton Ave
Baltimore, MD 21201
PHONE: 410-661-4670 FAX: 14106614671 NPI: 1073036562

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 : 02/04/2026

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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crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Zhao, Fei

SN Careplans

SN WK1: 1 (02/17/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK5: 1 (03/15/26-03/21/26) ,WK6: 1 (03/22/26-03/28/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 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; 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M1700 - Cognition, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, M2020 - Oral Med Management, coughing, M1400 - Dyspnea, M1033 - Exhaustion, M1600 - UTI, muscle weakness, limited range of motion, poor muscle tone, limited strength, muscle spasms, limited endurance, difficulty sleeping, weak hand grips, daytime fatigue, balance deficit

PROCEDURES: incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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 medicatio, * 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) purpos, * 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, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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, caregiver administers and/or packages medications appropriately

SN Goals

PATIENT-STATED GOAL: Patient wants to regain some movement she lost on her left side of her body with therapy.

GOALS
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) purpos

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 medicatio

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

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

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

caregiver administers and/or packages medications appropriately

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

02/17/2026

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PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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- : - medications reviewed with patient/caregiver, cough/deep breathing exercises, 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 medicatio, * 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 - 05. Setup or clean-up 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, 1 - Step (curb) - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Medication Review

PATIENT-STATED GOAL: To be able to walk without help

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 medicatio

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

Toilet Transfer - 05. Setup or clean-up 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

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

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

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

Medication Review

OT Careplans

OT WK1: 1 (02/17/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK5: 1 (03/15/26-03/21/26) ,WK6: 1 (03/22/26-03/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: , Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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: cough/deep breathing exercises, therapeutic exercises, equipment training, work simplification/energy conservation, dynamic standing balance exercises, 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 medicatio, * 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 relaxatio, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate 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 - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: To move better

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 medicatio

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 relaxatio

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate 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 - 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 RN	02/17/2026