

Home Health Certification and Plan of Care				Order ID: 1150/16387	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
18197365		02/19/2026		From: 02/19/2026 To: 04/19/2026	
4. Medical Record No.		5. Provider No.		3329	
217058					
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Edward Hartlove 8119 Parkway Road, CURTIS BAY, MD 21226- 443-883-1914			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
05/15/1961			Male		
11. ICD		Principal Diagnosis		Date	
I69.352		Hemiplga following cerebral infrc aff left dominant side		02/19/26	
13. ICD		Other Pertinent Diagnoses		Date	
I69.320		Aphasia following cerebral infarction		02/19/26	
I25.10		Athscl heart disease of native coronary artery w/o ang pctrs		02/19/26	
I11.0		Hypertensive heart disease with heart failure		02/19/26	
I50.22		Chronic systolic (congestive) heart failure		02/19/26	
E11.9		Type 2 diabetes mellitus without complications		02/19/26	
E78.5		Hyperlipidemia unspecified		02/19/26	
I42.9		Cardiomyopathy unspecified		02/19/26	
Z79.01		Long term (current) use of anticoagulants		02/19/26	
Z79.84		Long term (current) use of oral hypoglycemic drugs		02/19/26	
Z79.82		Long term (current) use of aspirin		02/19/26	
Z95.1		Presence of aortocoronary bypass graft		02/19/26	
Z87.891		Personal history of nicotine dependence		02/19/26	
14. DME and Supplies:			15. Safety Measures:		
None of the above			standard precautions, medication safety		
16. Nutrition:			17. Allergies:		
Z. NO PHYSICIAN-ORDERED DIET			no known allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
Ambulation			No Restrictions, Up As Tolerated		
19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No					
20. Prognosis: good					
22. A Rehabilitation Potential:			22.B.Discharge Plans		
SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.			patient will be responsible for managing treatment		
Homebound status: Due to diagnosis of Hemiplegia following cerebral infarction affecting left 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:		<p class="MsoNoSpacing">The patient is a 64-year-old left-hand-dominant male with a significant medical history of prior ischemic stroke (December 2023), coronary artery disease status post CABG 2 (March 2024), chronic systolic heart failure with reduced ejection fraction (HFrEF, EF 30-35%), hypertension, type 2 diabetes mellitus, and hyperlipidemia. He was admitted to home health following a recent acute care and skilled nursing facility stay related to an acute ischemic stroke and hypothermia after a fall on ice, during which he remained outside for approximately one hour before being found. MRI confirmed an acute right prefrontal infarct without hemorrhage. He presented with left upper extremity weakness greater than left lower extremity weakness, left facial droop, expressive aphasia/dysarthria, impaired coordination, and balance deficits. Anticoagulation with dabigatran (Pradaxa) was previously held due to a gastrointestinal bleed but has been restarted in collaboration with Neurology and Cardiology for secondary stroke prevention, along with continued aspirin therapy for CAD. Currently, the patient denies pain, is alert and actively participates in therapy, ambulates indoors without an assistive device but with a slight left-sided limp, and requires supervision for basic ADLs and ambulation due to fall risk. Lungs are clear to auscultation, bowel sounds are present, pulses are palpable, and vital signs are stable. He lives with his spouse in a multi-level home, who was present during the visit and is a reliable historian. The patient's goal is to return to work and driving, and he would benefit from continued skilled OT services to address coordination deficits, improve safety with ADLs, and reduce fall risk.</p><p class="MsoNoSpacing">Date of Order</p><p class="MsoNoSpacing">02/19/2026
Order</p><p class="MsoNoSpacing">Physician Face-to-Face Date: 02/12/2026
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Hemiplegia following cerebral infarction affecting left 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</p><p class="MsoNoSpacing">1 - SOC - SN Notes: </p><p class="MsoNoSpacing">PT Eval Notes:
OT Eval Notes:</p><p class="MsoNoSpacing">Physician: Haney, Richard</p>			
SN Careplans			SN Goals		
23. Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT		
Electronically Signed by Messick, Charles RN on 02/19/2026					
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.		
Richard Haney 7670 Quarterfield Rd, Glen Burnie, MD 21061 PHONE: 410-508-7650 FAX: NPI: 1447665732			F2F date : 02/12/2026		
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.		
: Date of physician last face-to-face			PAGE 1 of 3		

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SN WK1: 1 (02/19/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) 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, blood sugar < 60 > 300 CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance HOSPITALIZATION RISKS: 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 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:No Advance Directive PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, heartburn/indigestion, limited strength, balance deficit, pallor PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, home exercise program 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule			PATIENT-STATED GOAL: I want to get back to work within the next 2 weeks 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 self-administers medications as prescribed * recalls related medication(s) purpose, schedule			
PT Careplans PT WK2: 3 (02/22/26-02/28/26) ,WK3: 2 (03/01/26-03/07/26) PROBLEMS IDENTIFIED ON ASSESSMENT: 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: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention TEACH PATIENT/CAREGIVER: 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			PT Goals PATIENT-STATED GOAL: I just want to get back to walking the way that I used to. 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 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			
Signature of Physician:			Date PAGE 2 of 3			
Optional Name/Signature of Nurse/Therapist: Electronically Signed by Messick, Charles RN			Date 02/19/2026			

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		12 Steps - 05. Setup or clean-up assistance Picking Up Object - 05. Setup or clean-up assistance		
OT Careplans OT WK1: 1 (02/19/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) PROBLEMS IDENTIFIED ON ASSESSMENT: , M1400, 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, equipment training, work simplification/energy conservation 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent		OT Goals PATIENT-STATED GOAL: To go back to work 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 Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Shower/Bathe Self - 06. Independent Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent		

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