Home Health Certification and Plan of Care

Order ID: 1150/16414

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1T07QX3FA39	02/19/2026	From: 02/19/2026 To: 04/19/2026	22619	217058

6. Patient's Name and Address

Frieda Warfield
6722 Collinsdale Road,
PARKVILLE, MD 21234-
443-324-2545

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 11/18/1945 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I69.351	Hemiplga following cerebral infrc aff right dominant side	02/19/26

13. ICD	Other Pertinent Diagnoses	Date
G35.D	Multiple sclerosis unspecified	02/19/26
E78.5	Hyperlipidemia unspecified	02/19/26
G40.909	Epilepsy unsp not intractable without status epilepticus	02/19/26
I10.	Essential (primary) hypertension	02/19/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	02/19/26
H40.10X0	Unspecified open-angle glaucoma stage unspecified	02/19/26
E66.9	Obesity unspecified	02/19/26
Z79.01	Long term (current) use of anticoagulants	02/19/26
Z79.82	Long term (current) use of aspirin	02/19/26
Z86.718	Personal history of other venous thrombosis and embolism	02/19/26
Z99.3	Dependence on wheelchair	02/19/26
Z87.440	Personal history of urinary (tract) infections	02/19/26
Z95.1	Presence of aortocoronary bypass graft	02/19/26

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

ELIQUIS 2.5 mg / 1 Tablet by mouth twice a day for CAD
CARBAMAZEPINE ER 300 mg / 1 Capsule by mouth once a day for seizures
Sennosides-Docusate Sodium 8.6-50 mg / 1 Tablet by mouth as necessary Give 2 tablet for bowel regimen
Acetaminophen - Acetaminophen 325 mg / 1 Tablet by mouth every 4 hours Give 2 tablet as needed for pain
Aspirin 81Mg - Aspirin / 1 Tablet by mouth once a day for prophylaxis
Atorvastatin Calcium - Atorvastatin Calcium 80 mg / 1 Tablet by mouth at bedtime for HLD
Brimonidine Tartrate - Brimonidine Tartrate 0.2 perc Instill 1 drop both eyes twice a day for Glaucoma
Dorzolamide Hydrochloride And Timolol Maleate - Dorzolamide Hydrochloride: Timolol Maleate eq 2 perc base;eq 0.5 perc base Instill 1 drop both eyes twice a day for Glaucoma
Polyethylene Glycol 3350 - Polyethylene Glycol 3350 17gm/scoopful Powder by mouth as necessary for bowel regimen Q day Mix with 6 - 8 ounce of fluids
FUROSEMIDE 0 20 mg / 1 Tablet by mouth once a day for EDEMA
Spironolactone - Spironolactone 25 mg 25 mg / 1 Tablet by mouth once a day Give 12.5 mg for Edema
Multiple Vitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 0 1 Tablet by mouth once a day for Supplement
Losartan Potassium - Losartan Potassium 100 mg 100 mg / 1 Tablet by mouth once a day for HTN
Hydralazine Hydrochloride - Hydralazine Hydrochloride 10 mg 10 mg / 1 Tablet by mouth twice a day for HTN

14. DME and Supplies:

hospital bed, cane, 4 wheeled walker, commode, grab bars, walker, wheelchair, rolling walker, hand held shower, bath bench

15. Safety Measures:

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

16. Nutrition:

regular

17. Allergies:

penicillin

18.A. Functional Limitations

Endurance, Bowel/Bladder Incontinence, Ambulation

18.B. Activities Permitted

Wheelchair, Exercises Prescribed, Up As Tolerated

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: 2. On awakening or at night 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: No

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

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 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 an 80-year-old female seen today for start of care and follow-up after a recent hospitalization in December 2025 for weakness and altered mental status, during which she was treated for a urinary tract infection and influenza. Following acute care, she completed a subacute rehabilitation stay at Roland Park Rehabilitation and has since returned home. Her past medical history is significant for cerebrovascular accident with right-sided hemiparesis, progressive multiple sclerosis resulting in functional dependency, hypertension, glaucoma, seizure disorder, encephalopathy, cognitive deficits, and a history of acute kidney injury. The patient remains wheelchair dependent with markedly limited mobility and has not resumed meaningful ambulation since returning home. At baseline prior to hospitalization, she required assistance for all transfers and activities of daily living, was able to ambulate short distances with assistance using a walker, and utilized a wheelchair but was unable to independently negotiate it. The patient resides in a single-family split-level home with her two sons, who serve as her primary caregivers. She occupies a private room and living area in the basement with a separate rear entrance. The home is equipped with a manual crank hospital bed; caregivers have expressed interest in obtaining a fully electric hospital bed to facilitate safer positioning and transfers. Additional durable medical equipment includes a wheelchair, walker, and bedside commode. The patient is designated as full code with a MOLST on file. All prescribed medications are available in the home and organized using a weekly pillbox system, which is filled by the patient's daughter, who is a nurse. On assessment, the patient was resting comfortably but demonstrated significant functional impairments. She presents with impaired balance, gait dysfunction, deficits in transfers and bed mobility, lower extremity weakness, decreased bilateral upper extremity strength, poor standing balance and tolerance, and limited overall activity tolerance. Standardized balance assessments such as the Timed Up and Go (TUG) and Tinetti were unable to be completed due to the severity of deficits. She requires assistance for stand-pivot transfers at most and demonstrates a high fall risk with taxing effort required to leave the home. During the evaluation, she required frequent encouragement to

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/19/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Michaelle Halaby Holmes
1838 Greene Tree Rd
Pikesville, MD 21208
PHONE: 4434710469 FAX: 14105841883 NPI: 1932105137

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 : 01/26/2026

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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participate and displayed limited motivation. Her son was present and actively assisted; education was provided regarding safe transfer techniques, including the use of two-person assistance for repositioning in the chair, which he verbalized understanding. From a rehabilitation perspective, the patient demonstrates decreased independence with self-care tasks, functional transfers, and functional ambulation secondary to impaired strength, balance, and endurance. Skilled physical therapy is indicated to address lower extremity weakness, balance deficits, transfer training, and fall prevention. Skilled occupational therapy is recommended to focus on upper extremity strengthening, energy conservation, adaptive techniques, and maximizing independence with activities of daily living. Given her chronic neurologic conditions and current deconditioned state, she has fair rehabilitation potential with consistent caregiver support and skilled intervention. The plan of care includes ongoing skilled home health services to address safety, mobility, strength, and functional independence while providing continued caregiver education and fall risk mitigation strategies.
 Date of Order 02/19/2026 Orders Physician Face-to-Face Date: 01/26/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Hemiplegia And Hemiparesis 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
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Halaby Holmes, Michaelle

SN Careplans

SN WK1: 1 (02/19/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26) ,WK4: 1 (03/08/26-03/14/26) ,WK6: 1 (03/22/26-03/28/26) ,WK8: 1 (04/05/26-04/11/26)

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, 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, 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M1700 - Cognition, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, M2020 - Oral Med Management, dependent edema, M1033 - Exhaustion, M1400 - Dyspnea, M1620 - Bowel Incontinence, constipation, frequent urination, limited endurance, muscle spasms, limited strength, swelling of affected area, poor muscle tone, muscle weakness, limited range of motion, impaired speech, daytime fatigue, lethargy, balance deficit, B1000 - Vision Deficit, difficulty sleeping, weak hand grips, withdrawal from conversations, obesity

PROCEDURES: cough/deep breathing exercises, apply anti-embolitic stockings, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for

SN Goals

PATIENT-STATED GOAL: The CG states he wants the patient to be able to walk again so it makes transfers much easier.

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 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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* 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/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* 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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/19/2026

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adequate patient supervision, coordinate/arrange resources for vision-impaired

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, * 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, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, 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, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (02/19/26-02/21/26) ,WK2: 2 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK5: 1 (03/15/26-03/21/26) ,WK7: 1 (03/29/26-04/04/26) ,WK9: 1 (04/12/26-04/18/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, Pain Effect on Sleep, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170S1 - Wheel 150 feet

PROCEDURES: cough/deep breathing exercises, wheelchair training, home exercise program: Laq, hip flexion, hip abduction, heelraises, hamstring curls, supine exercises, dynamic standing balance exercises, 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 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 - 03. Partial/moderate assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 Feet - 02. Substantial/maximal assistance

PT Goals

PATIENT-STATED GOAL: To be able to assist more with bed mobility, standing and walk again with the Walker.

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 - 03. Partial/moderate assistance

Car Transfer - 05. Setup or clean-up assistance

Walk 10 Feet - 02. Substantial/maximal assistance

OT Careplans

OT WK2: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK6: 1 (03/22/26-03/28/26) ,WK8: 1 (04/05/26-04/11/26)

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

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 - 03. Partial/moderate assistance, Toileting Hygiene - 03. Partial/moderate assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 03 Partial/moderate assistance, Lower Body Dressing - 01. Dependent, Don/Doff Footwear - 01. Dependent, Eating - 05. Setup or clean-up assistance

OT Goals

PATIENT-STATED GOAL: Get in the shower

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

Oral Hygiene - 03. Partial/moderate assistance

Toileting Hygiene - 03. Partial/moderate assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Upper Body Dressing - 03. Partial/moderate assistance

Lower Body Dressing - 01. Dependent

Don/Doff Footwear - 01. Dependent

Eating - 05. Setup or clean-up assistance

HHA Careplans

HHA 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)

HHA Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

02/19/2026