Home Health Certification and Plan of Care

Order ID: 1150/17311

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
98348200	03/19/2026	From: 03/19/2026 To: 05/17/2026	23590	217058

6. Patient's Name and Address

Altes Chery
124 Warwickshire Ln Apt.B,
GLEN BURNIE, MD 21061-
757-709-2585

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 12/01/1976 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I69.354	Hemiplga following cerebral infrc affecting left nondom side	03/19/26

13. ICD	Other Pertinent Diagnoses	Date
I69.320	Aphasia following cerebral infarction	03/19/26
I69.191	Dysphagia following nontraumatic intracerebral hemorrhage	03/19/26
I10.	Essential (primary) hypertension	03/19/26
G91.1	Obstructive hydrocephalus	03/19/26
G93.5	Compression of brain	03/19/26
I77.71	Dissection of carotid artery	03/19/26
H49.22	Sixth [abducent] nerve palsy left eye	03/19/26
D64.9	Anemia unspecified	03/19/26
Z79.01	Long term (current) use of anticoagulants	03/19/26

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

Amlodipine - Amlodipine Besylate 10mg; 1 tab by mouth once a day blood pressure
Carvedilol - Carvedilol 25 mg 25mg; 1 tab by mouth twice a day blood pressure
Hydralazine - Hydralazine Hydrochloride 100mg; 1 tab by mouth three times a day blood pressure
Losartan 100 mg; 1 tab by mouth once a day blood pressure

14. DME and Supplies:

None of the above

15. Safety Measures:

supervision at all times, , , , ambulates with assistance,

16. Nutrition:

low sodium,

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance, left hemiplegia

18.B. Activities Permitted

Exercises Prescribed

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: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:

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.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment
patient 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:

The patient is a 49-year-old male with a recent history of right thalamic intracranial hemorrhage secondary to hypertension, complicated by cerebrovascular accident (CVA) with left hemiplegia, aphasia, dysphagia, and previously resolved obstructive hydrocephalus requiring external ventricular drain (EVD) placement, which was removed on 02/19/26. His medical history is also significant for intraventricular hemorrhage, cerebral herniation, extracranial carotid artery dissection, cranial nerve VI palsy on the left, congenital exotropia of the left eye, and hypertension. The patient was initially hospitalized in mid-February 2026 and subsequently transferred to an acute rehabilitation facility for approximately one month. He experienced an episode of fever, elevated blood pressure, and tachycardia on 03/06/26, prompting transfer to the emergency department for evaluation, where testing for COVID-19, influenza, and RSV was negative. The patient is a poor historian due to aphasia related to his stroke. The patient currently resides in an apartment with his spouse and four children, with family members available at all times to assist with care. Prior to his stroke, he was independent, working and driving. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient is alert and oriented to person, place, and time, though he demonstrates communication difficulties and frequently speaks in his native language. He denies pain and shortness of breath, although he intermittently reports episodes of shortness of breath, particularly at night. Lung sounds are clear to auscultation throughout. He reports a good appetite, with last bowel movement occurring the previous day. The patient exhibits decreased endurance, left-sided weakness, mild facial nerve palsy, and some peripheral visual deficits. He is not currently using any assistive device for ambulation, as none was recommended; however, he demonstrates an unsteady gait, decreased balance, and reduced safety awareness, placing him at increased risk for falls despite no reported history of falls. The home environment includes six steps to enter and is described as somewhat cluttered, further contributing to fall risk. The patient also has cranial sutures in place, with no current orders for removal, and he missed a scheduled physician follow-up appointment on 03/17/26, for which his daughter has been instructed to reschedule. Skilled nursing services were initiated with a planned frequency of 1 visit per week for 2 weeks, followed by 1 visit every 2 weeks for 3 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh>. Physical and occupational therapy evaluations have been ordered. During the visit, all medications were reviewed with the patient and caregiver, including dosage, frequency, and potential side effects, and education was provided regarding the importance of strict adherence to the prescribed medication regimen, particularly for hypertension management and stroke prevention. Additional education was initiated regarding CVA, dysphagia precautions, and hypertension management, with both the patient and family demonstrating receptiveness. Physical therapy <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> identified deficits including decreased functional mobility, impaired balance, unsteady gait, decreased safety awareness, and reduced endurance. The patient was instructed in safe ambulation techniques on level surfaces without an assistive device and required standby assistance for safe mobility, with cues provided to improve bilateral step height, step length, and overall safety. Standardized <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>s, including the Tinetti and Timed Up and Go (TUG), were performed. The patient was educated on the importance of routine ambulation to improve circulation and prevent complications of immobility, and a progressive walking program was initiated, starting with short walks every 1-2 hours within the home and gradually increasing duration from 3-5 minutes as tolerated. Occupational therapy evaluation indicates a need for skilled services to improve muscle strength, coordination, and independence with basic activities of daily living (BADLs). A comprehensive plan of care was developed in collaboration with the patient and caregiver, who are in agreement. The patient will receive home physical therapy services beginning 03/23/26 at a frequency of twice weekly for two weeks, then once weekly for two additional weeks. Due to the patient's condition, he is considered homebound, requiring human assistance to leave the home, and exertion associated with leaving poses a safety risk. Continued skilled services are necessary to reduce fall risk, improve functional independence, and prevent further decline.
 Date of Order 03/19/2026 Orders Physician Face-to-Face Date: 03/16/2026 Clinical Condition Requiring Home Care per Certifying Physician: Home Health Skilled Nursing, Home Health Physical Therapy, Home Health

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/19/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Nkemdilim Adimorah
5401 Old Court Rd
Randallstown, MD 21133
PHONE: 4436350583 FAX: NPI: 1841941242

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 : 03/16/2026

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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PT Safety Evaluation, Home Health Occupational Therapy 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 crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc OT Eval Notes: PT Eval Notes: Physician Adimorah, Nkemdilim

SN Careplans

SN WK1: 8 (03/19/26-03/21/26)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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: M2020 - Oral Med Management, Home Safety, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, limited endurance, balance deficit

PROCEDURES: cough/deep breathing exercises, home exercise program, coordinate/arrange for maintenance of clean/uncluttered living area

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, * 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, patient's living environment is clean/uncluttered, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: I WANT TO BE ABLE 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 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

patient's living environment is clean/uncluttered

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 2 (03/22/26-03/28/26) ,WK3: 2 (03/29/26-04/04/26) ,WK4: 1 (04/05/26-04/11/26) ,WK5: 1 (04/12/26-04/18/26)

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: 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

PT Goals

PATIENT-STATED GOAL: To get back to being able to do everything by myself

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/19/2026

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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

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 - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

* recalls related medication(s) purpose, schedule

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

OT Careplans

OT WK1: 8 (03/19/26-03/21/26)

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 exercise , Medication review , cough/deep breathing exercises, equipment training, work simplification/energy conservation, 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, 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 be able to work again

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Shower/Bathe Self - 06. Independent

Eating - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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