Home Health Certification and Plan of Care

Order ID: 1150/17661

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
53120875	03/28/2026	From: 03/28/2026 To: 05/26/2026	24248	217058

6. Patient's Name and Address

Michael Briggs
2830 ALABAMA AVE,
HALETHORPE, MD 21227-
443-529-7772

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 12/20/1965 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I69.351	Hemiplga following cerebral infrc aff right dominant side	03/28/26

13. ICD	Other Pertinent Diagnoses	Date
E11.65	Type 2 diabetes mellitus with hyperglycemia	03/28/26
F33.0	Major depressive disorder recurrent mild	03/28/26
F41.9	Anxiety disorder unspecified	03/28/26
I10.	Essential (primary) hypertension	03/28/26
E11.69	Type 2 diabetes mellitus with other specified complication	03/28/26
E78.49	Other hyperlipidemia	03/28/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	03/28/26
Z79.4	Long term (current) use of insulin	03/28/26
Z79.82	Long term (current) use of aspirin	03/28/26

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

insulin glargine-yfgn (SEMGLEE PEN) 100 unit/mL (3 mL) / Inject 30 Units subcutaneous once a day DM
insulin aspart-xjhz (KIRSTY) 100 unit/mL / Inject 6 Units subcutaneous three times a day before meals DM
LOPRESSOR 25 mg / 1 Tablet by mouth twice a day BLOOD PRESSURE
Zestril - Lisinopril 20 mg / 1 Tablet by mouth daily BLOOD PRESSURE
LIPITOR eq 40 mg base 40 mg / 2 TABS by mouth daily for cholesterol and heart protection
BUSPAR 15 mg 15 mg / 1 Tablet by mouth twice a day as needed for anxiety
ASPIRIN Chewable 81 mg / 1 Tablet by mouth daily Chew and swallow PROPHYLACTIC

14. DME and Supplies:

walker, diabetic supplies

15. Safety Measures:

diabetic precautions, , ambulates with device, walker precautions, , ambulates with assistance, transfer with assist, supervision at all times, sharps precautions, activity supervision

16. Nutrition:

cardiac diet, diabetic,

17. Allergies:

metformin

18.A. Functional Limitations

Endurance, Ambulation, Amputation, right sided weakness

18.B. Activities Permitted

Walker, Up As Tolerated, 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: Yes

20. Prognosis: fair

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 the 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 a 60-year-old male with a significant past medical history including cerebrovascular accident (January 2026) with residual right-sided weakness, type 2 diabetes mellitus with hyperglycemia, coronary artery disease, hypertension, hyperlipidemia, chronic diarrhea, major depressive disorder, and anxiety. The patient also has a history of left below-ankle amputation and prior myocardial infarction in 2015. Since the stroke, the patient reports persistent neurological and functional deficits, including dizziness, impaired balance, decreased peripheral vision, diplopia, inability to see from the right eye, and visual disturbances such as seeing shadows. He also reports right-sided body pain, fatigue with minimal activity, light sensitivity, and difficulty performing self-care tasks, requiring approximately 45 minutes to complete bathing. Fine motor deficits are present, including decreased dexterity and impaired sensation in the hands and left toes, limiting the ability to perform tasks such as buttoning clothing or tying a tie. The patient is alert and oriented, able to respond appropriately, but presents with anxiety, irritability, and periods of agitation. He denies shortness of breath, and lung sounds are clear. He denies pain at rest but reports intermittent discomfort during activity. Appetite is variable, and the patient reports chronic nocturnal diarrhea occurring approximately five times per week since hospital discharge in February 2026, with worsening symptoms. Last bowel movement was reported today. The patient ambulates with a walker and demonstrates poor balance and an unsteady gait, placing him at increased fall risk. He requires minimal assistance for basic activities of daily living and functional mobility and relies on his life partner for support with both ADLs and instrumental activities of daily living. Diabetes management remains suboptimal, with a recent hemoglobin A1c of 12.8 (increased from 10.5) and a recent fingerstick glucose reading of 218 mg/dL. The patient is currently prescribed long-acting insulin (30 units daily) but is not using short-acting insulin as indicated. A continuous glucose monitoring system (Freestyle Libre) is anticipated. Skilled nursing reviewed all medications, including dosages, frequency, and potential side effects. It was noted that the patient's prescription for clopidogrel (Plavix) was depleted; follow-up has been initiated with Kaiser for medication refill. Functionally, the patient exhibits decreased endurance, requiring frequent rest periods, including sitting every 1.5 hours due to fatigue and phantom limb discomfort. He reports sleeping in a recliner due to increased pain when lying flat. Despite no reported falls in the past year, the patient remains at high risk due to impaired balance, visual deficits, and generalized weakness. He expresses a desire to return to work but demonstrates limited insight into current functional limitations, contributing to emotional distress. Skilled nursing services are ordered at a frequency of 1 visit per week for 2 weeks, then 1 visit per week for 5 weeks, with physical and occupational therapy evaluations also ordered. Education was initiated regarding diabetes management, dietary modifications, and stroke recovery; however, the patient requires ongoing reinforcement to improve understanding and compliance. Caregiver education was also provided, with the caregiver demonstrating receptiveness to instruction. Skilled therapy services are medically necessary to address deficits in strength, balance, coordination, endurance, and functional mobility, as well as to improve independence in activities of daily living and prevent further decline, falls, and complications. The plan of care includes continued monitoring of glycemic control, neurological status, gastrointestinal symptoms, medication adherence, safety awareness, and response to therapeutic interventions, along with ongoing patient and caregiver education.
 Date of Order 03/28/2026 Orders Physician Face-to-Face Date: 03/27/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN: <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">Assessment</mh> & Education for diseases/conditions/medications, PT: <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">Assessment</mh> & treatment, OT: ADL training; Energy conservation due to Hemiplegia and hemiparesis following cerebral infarction affecting the 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 OT Eval Notes: PT Eval Notes: Physician Madah, Maria

SN Careplans	SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/28/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Maria Madah
1701 Twin Springs Rd
Halethorpe, MD 21227
PHONE: (800) 777-7904 FAX: 18559024974 NPI: 1952892846

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 : 03/27/2026

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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SN WK1: 1 (03/28/26-03/28/26) ,WK2: 2 (03/29/26-04/04/26) ,WK3: 2 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26) ,WK6: 1 (04/26/26-05/02/26) ,WK7: 1 (05/03/26-05/09/26) ,WK8: 1 (05/10/26-05/16/26)

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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, limited strength, balance deficit, B1000 - Vision Deficit

PROCEDURES: cough/deep breathing exercises, glucose testing via monitor: PT/CG TO MONITOR FINGER STICK AC/HS, 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 medication(s) purpose, schedule, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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) 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, meal preparation is available to patient for all meals

PATIENT-STATED GOAL: i want to get better

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) purpose, schedule

patient/caregiver recalls
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

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/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

meal preparation is available to patient for all meals

OT Careplans

OT WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26) ,WK6: 1 (04/26/26-05/02/26) ,WK7: 1 (05/03/26-05/09/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea, Pain Effect on Sleep, GG0130A1 - Eating, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on

OT Goals

PATIENT-STATED GOAL: Be able to go out, go back to plof

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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
03/28/2026

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Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns

PROCEDURES: cough/deep breathing exercises, incentive spirometer, 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, * 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

Shower/Bathe Self - 05. Setup or clean-up assistance

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
* 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 - 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

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/28/2026