Home Health Certification and Plan of Care

Order ID: 1150/17999

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1WE5YT8PJ99	02/14/2026	From: 04/15/2026 To: 06/13/2026	22584	217058

6. Patient's Name and Address

Rosa Moore
4004 Emmart Avenue,
Baltimore, MD 21215-
443-814-1791

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 07/28/1948 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
J18.8	Other pneumonia unspecified organism	02/14/26

13. ICD	Other Pertinent Diagnoses	Date
I69.351	Hemiplga following cerebral infrc aff right dominant side	02/14/26
I69.391	Dysphagia following cerebral infarction	02/14/26
E11.319	Type 2 diabetes w unsp diabetic rtnop w/o macular edema	02/14/26
I11.0	Hypertensive heart disease with heart failure	02/14/26
I50.31	Acute diastolic (congestive) heart failure	02/14/26
I48.0	Paroxysmal atrial fibrillation	02/14/26
D72.829	Elevated white blood cell count unspecified	02/14/26
E78.5	Hyperlipidemia unspecified	02/14/26
K21.9	Gastro-esophageal reflux disease without esophagitis	02/14/26
E07.89	Other specified disorders of thyroid	02/14/26
E55.9	Vitamin D deficiency unspecified	02/14/26
K59.00	Constipation unspecified	02/14/26
Z43.1	Encounter for attention to gastrostomy	02/14/26
Z79.01	Long term (current) use of anticoagulants	02/14/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	02/14/26
Z74.01	Bed confinement status	02/14/26
U07.1	COVID-19	02/14/26
I95.9	Hypotension unspecified	02/14/26
E11.65	Type 2 diabetes mellitus with hyperglycemia	02/14/26
R33.9	Retention of urine unspecified	02/14/26
Z96.0	Presence of urogenital implants	02/14/26

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

FUROSEMIDE 20 mg / 1 Tablet PEG TUBE in the morning for HTN
ELIQUIS 5 mg / 1 Tablet PEG TUBE twice a day for prevent DVT
Acetaminophen - Acetaminophen 325 mg / 1 Tablet by mouth every 8 hours Give 2 tablet as needed for discomfort/pain Total Dose 650mg *DO NOT EXCEED 3 GRAMS per 24 HOURS*
Digoxin - Digoxin 0.125 mg / 1 Tablet PEG TUBE in the morning for Afib Hold for pluse <60
Entresto - Sacubitril: Valsartan 49-51 mg / 1 Tablet PEG TUBE twice a day for HTN
Pravastatin Sodium - Pravastatin Sodium 20 mg / 1 Tablet PEG TUBE in the evening for LDL
Dapagliflozin Propanediol 5 mg / 1 Tablet by mouth in the morning for DM (Farxiga)

14. DME and Supplies:

hospital bed, feeding pump, diabetic supplies

15. Safety Measures:

bleeding precautions, fall precautions, restricted ROM, standard precautions, transfer with assist, supervision at all times, bedrails up while in bed, activity supervision

16. Nutrition:

low cholesterol, diabetic

17. Allergies:

lisinopril

18.A. Functional Limitations

Endurance, Speech

18.B. Activities Permitted

Complete Bedrest

19. Mental & Pyschosocial Status: COGNITION: 4. Is totally dependent in toileting., ANXIETY: NA Patient nonresponsive, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: , MOBILITY:

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 Other pneumonia unspecified organism, 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: Start of care was completed for this 77-year-old female referred to home health services for medication management and rehabilitation following a recent cerebrovascular accident (CVA) resulting in right-sided hemiparesis and significant functional decline. Her past medical history is significant for vascular dementia, cerebral infarction with right-sided hemiparesis, dysphasia, type 2 diabetes mellitus (currently without prescription management), hypertension, congestive heart failure, atrial fibrillation, hyperlipidemia, gastroesophageal reflux disease, thyroid disease, vitamin D deficiency, constipation, history of anticoagulant use, and prior hypoglycemic episodes. The patient is bedbound and requires maximal assistance and supervision for all mobility and activities of daily living, making it a taxing effort to leave the home. She resides with family members who provide 24-hour supervision and rotating caregiving support. Consents were signed electronically. There is no advanced directive on file. Prior to hospitalization, the patient was living independently and ambulating without an assistive device. She recently returned home after a three-month rehabilitation stay. At present, she is confined to a hospital bed located in the living room with bedrails in place and requires total assistance for transfers, utilizing a Hoyer lift. The current Hoyer sling is reported to be too small and lacks head support, posing safety concerns. A geri-chair is present but is non-reclining and not fully functional despite attempted repair. The family is working with the durable medical equipment provider to address these equipment issues. The patient demonstrates 0-1/5 manual muscle strength in the right lower extremity and requires maximal assistance for bed mobility and is dependent for transfers. She exhibits poor tolerance to passive movement of both upper extremities due to pain. There is an active order for acetaminophen 325 mg; however, the family has not been administering it. Education was provided regarding appropriate pain management to facilitate positioning, hygiene, and participation in therapy. The primary care provider will be notified to discuss pain control options and arrange a video visit. The patient is nonverbal with no expressive language and inconsistently follows one-step commands. Despite dysphasia, she is able to consume food and fluids orally and demonstrates adequate swallowing function. A gastrostomy tube is intact to the abdomen; however, there are currently no flush supplies available in the home. A referral to gastroenterology is pending for further evaluation and management of the gastrostomy tube. The patient is incontinent of bowel and bladder. The last bowel movement was reported as large and soft on the previous evening. Appetite is reported as good, with intake including grits, eggs, sausage, and fruit. No wounds or areas of skin breakdown were noted on assessment; however, caregivers report difficulty with routine repositioning due to the patient's pain. Education was provided on frequent repositioning, pressure relief, and skin integrity preservation. No abnormal bleeding has been reported. Vital and medication review was completed. Discrepancies were identified, including a prescription for Protonix not currently present in the home, with the patient previously taking omeprazole.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/13/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

James Tansinda
726 Maiden Choice
Catonsville, MD 21228
PHONE: 14107441101 FAX: 14107441186 NPI: 1184690141

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 : 01/28/2026

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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The provider will be notified regarding medication reconciliation and clarification. Caregivers were instructed to have prescriptions filled at the pharmacy. No abnormal bleeding or acute distress was observed at the time of assessment. The patient was observed to respond affectively, including laughing with her granddaughter, indicating preserved emotional responsiveness. Skilled nursing services are ordered at a frequency of 1 visit per week for 6 weeks for medication management, chronic disease monitoring, gastrostomy tube oversight, and caregiver education. Skilled physical therapy is medically necessary to provide passive range of motion to the right lower extremity to prevent contracture formation, improve strength and positioning tolerance, and support functional mobility progression as appropriate. Occupational therapy is recommended at a frequency of 1 visit per week for 6 weeks to address activities of daily living retraining, therapeutic exercise, home exercise program development, functional mobility training, equipment assessment, and caregiver training. A home health aide is also ordered to assist with personal care needs. Caregivers have expressed interest in speech-language pathology services to address expressive language deficits; referral for speech therapy evaluation is appropriate given the patient's communication impairment and history of CVA. The overall plan of care focuses on maximizing comfort, preventing complications of immobility, improving safety, optimizing caregiver competence, and promoting the highest attainable level of functional independence within the home setting.
 Date of Order 04/13/2026 Orders Physician Face-to-Face Date: 01/28/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat HHA due to Other pneumonia unspecified organism Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home, other
 4 - Recertification Notes: Recert due to increased oral intake, avoid choking, and management of intact g tube until removal scheduled. Right side hemiparesis prevents pressure wounds with immobility, requiring maximum assistance, making it taxing efforts to leave the home. Physician Tansinda, James

SN Careplans

SN WK2: 1 (04/19/26-04/25/26) ,WK3: 1 (04/26/26-05/02/26) ,WK4: 1 (05/03/26-05/09/26) ,WK5: 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: 2. Non-agency caregiver(s) need training/supportive services to 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.

no wounds noted; 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: M1700 - Cognition, M2102d - Caregiver Performs Treatment, abnormal BS < 70/140 > mg/dL, swelling of affected area, limited range of motion, muscle weakness, limited strength, poor muscle tone, limited endurance, lethargy, balance deficit, impaired speech, daytime fatigue (NR), obesity

PROCEDURES: cough/deep breathing exercises, swallowing exercises, train caregiver(s) to perform medical/rehabilitation treatments, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, monitor intake & output

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

SN Goals

PATIENT-STATED GOAL: caregiver would like for patient to G tube removed and for patient to talk again.

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
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls
* strategies to increase caloric intake
* 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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/13/2026

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including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s, * strategies to increase caloric intake, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises 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, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (04/15/26-04/18/26) ,WK3: 1 (04/26/26-05/02/26) ,WK5: 1 (05/10/26-05/16/26) ,WK7: 1 (05/24/26-05/30/26) ,WK9: 1 (06/07/26-06/13/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170G1 - Car Transfer, GG0170S1 - Wheel 150 feet, GG0170R1 - Wheel 50 ft w 2 Turns, GG0170C1 - Lying to sitting/bed, GG0170B1 - Sit to Lying, GG0170A1 - Roll left & Right, GG0130B1 - Oral Hygiene, 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

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, postural correction exercises: Sitting balance at EOB with minimal support, home exercise program, therapeutic exercises: For BLE, AROM for LLE in supine or sitting. PROM for RLE in supine or sitting, equipment training, transfers training

TEACH PATIENT/CAREGIVER: * 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 - 02. Substantial/maximal assistance, Oral Hygiene - 03. Partial/moderate assistance, Toileting Hygiene - 03. Partial/moderate assistance, Upper Body Dressing - 03. Partial/moderate assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance

PT Goals

PATIENT-STATED GOAL: To be able to move R side again

GOALS
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

Chair to Bed to Chair - 02. Substantial/maximal assistance

Oral Hygiene - 03. Partial/moderate assistance

Toileting Hygiene - 03. Partial/moderate assistance

Upper Body Dressing - 03. Partial/moderate assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

OT Careplans

OT WK2: 1 (04/19/26-04/25/26)

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, 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, Oral Hygiene - 03. Partial/moderate assistance, Toileting Hygiene - 01. Dependent, Shower/Bathe Self - 02. Substantial/maximal 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: to get her out of bed (daughter)

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

Upper Body Dressing - 03. Partial/moderate assistance

Eating - 05. Setup or clean-up assistance

Oral Hygiene - 03. Partial/moderate assistance

Toileting Hygiene - 01. Dependent

Shower/Bathe Self - 02. Substantial/maximal assistance

Lower Body Dressing - 01. Dependent

Don/Doff Footwear - 01. Dependent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/13/2026