# Home Health Certification and Plan of Care

**Order ID: 1150/18341**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 42305934 | 04/28/2026 | From: 04/28/2026 To: 06/26/2026 | 25311 | 217058 |

**6. Patient's Name and Address**

Raymond Hierstetter
9503 HICKORY FALLS WAY,
NOTTINGHAM, MD 21236-
410-256-0109

**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** 09/23/1956 **9.Sex** Male

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| I69.351 | Hemiplga following cerebral infrc aff right dominant side | 04/28/26 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| M54.16 | Radiculopathy lumbar region | 04/28/26 |
| I10. | Essential (primary) hypertension | 04/28/26 |
| E11.42 | Type 2 diabetes mellitus with diabetic polyneuropathy | 04/28/26 |
| E78.00 | Pure hypercholesterolemia unspecified | 04/28/26 |
| I25.10 | Athscl heart disease of native coronary artery w/o ang pctrs | 04/28/26 |
| Z79.84 | Long term (current) use of oral hypoglycemic drugs | 04/28/26 |
| Z79.02 | Long term (current) use of antithrombotics/antiplatelets | 04/28/26 |
| Z79.82 | Long term (current) use of aspirin | 04/28/26 |

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

CLOPIDOGREL 75 mg / 1 Tablet by mouth daily for 21 days Commonly known as: PLAVIX.
CVA
ATORVASTATIN 80 mg / 1 Tablet by mouth nightly Commonly known as: LIPITOR
CHOLESTEROL
lisinopril-hydrochlorothiazide 20-12.5 mg/tablet / Take 2 tablets by mouth daily Commonly known as: ZESTORETIC
BLOOD PRESSURE
METFORMIN 1000 mg / 1 Tablet by mouth 2 times daily For diagnoses: Diabetic polyneuropathy associated with type 2 diabetes mellitus (CMS/HHS-HCC). Commonly known as: GLUCOPHAGE
GABAPENTIN 400 mg 400 mg / 1 Capsule by mouth 2 times daily Commonly known as: NEURONTIN
PAIN
Multivitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 TAB by mouth once a day SUPPLEMENT
Cinnamon - Cinnamon 1000MG; 1 TAB by mouth once a day SUPPLEMENT
ASPIRIN 81 mg / 1 Tablet by mouth daily CVA
PIOGLITAZONE 15 mg 15 mg / 1 Tablet by mouth daily For diagnoses: Type 2 diabetes mellitus with diabetic neuropathy, without long-term current use of insulin (CMS/HHS-HCC). Commonly known as: ACTOS
CO Q 10 100 mg / 1 Capsule by mouth 2 times daily with meals SUPPLEMENT
GLIMEPIRIDE 4 mg 4 mg / 1 Tablet by mouth daily For diagnoses: Diabetic polyneuropathy associated with type 2 diabetes mellitus (CMS/HHS-HCC). Commonly known as: AMARYL
ACETAMINOPHEN 325 mg/tablet / Give 2 tablet by mouth every 6 hours as needed for MILD Pain (or if patient requests it for moderate or severe pain) (for fever > 38.0 and notify physician). Commonly known as: TYLENOL

**14. DME and Supplies:**

diabetic supplies, walker

**15. Safety Measures:**

standard precautions, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, anticoagulant precautions, activity supervision

**16. Nutrition:**

cardiac diet, diabetic

**17. Allergies:**

motrin

**18.A. Functional Limitations**

Endurance, Ambulation, RIGHT SIDED WEAKNESS

**18.B. Activities Permitted**

Walker, Exercises Prescribed,

**19. Mental & Pyschosocial Status:** COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, 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**

patient will be responsible for managing treatment
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 a 69-year-old male referred to home health services following a recent hospital admission for acute cerebrovascular accident (CVA). The patient initially presented to the emergency department with concerns for stroke, including right-sided weakness and facial droop, and was diagnosed with a left-sided CVA resulting in right-sided hemiparesis. Past medical history is significant for lumbar radiculopathy/chronic back pain, hypertension, type 2 diabetes mellitus, dyslipidemia/hypercholesterolemia, atherosclerotic cardiovascular disease/atherosclerotic heart disease, and prior chiropractic treatment for back pain. The patient had previously been scheduled for an MRI related to back pain and has been prescribed gabapentin. The patient resides with his wife in a two-story home with the bedroom located on the second floor and three steps to enter the home. His son, daughter-in-law, and a friend also reside in the home and are available to provide assistance. Prior to this event, the patient was independent in the community, ambulated without an assistive device, independently negotiated stairs, completed ADLs and IADLs independently, owned a bar, and continued to work at times. Currently, the patient presents with right-sided weakness secondary to CVA, mild difficulty with transfers, gait dysfunction, impaired balance, and decreased safety with functional mobility. He is ambulating with a walker for safety and demonstrates an unsteady gait pattern, including Trendelenburg-type gait with pelvic drop to the left and inconsistent heel-toe pattern. The patient has difficulty negotiating stairs and is currently unable to lead with the right lower extremity, requiring a step-to pattern. Balance impairment is evidenced by a Tinetti score of 16/28 and a Timed Up and Go score of 18.2 seconds, indicating increased fall risk and need for skilled intervention. During the skilled nursing assessment, the patient was alert and oriented. He reported intermittent back pain but denied shortness of breath. Lung sounds were clear throughout. The patient reported a good appetite, and his last bowel movement was today. The spouse currently manages the patient's medications, and the spouse and family assist with all ADLs and IADLs as needed. Skilled nursing reviewed all medications with the patient and caregiver, including dose, frequency, purpose, and pertinent side effects. Education was initiated regarding CVA disease process, stroke recovery, signs and symptoms that require medical attention, fall prevention, safe use of assistive devices, and the importance of adherence to the prescribed medication regimen. Additional teaching was provided related to diet and disease process management for hypertension and diabetes mellitus, including the importance of blood pressure control, blood glucose management,

**23. Signature and Date of Verbal SOC Where Applicable:**

Electronically Signed by Messick, Charles RN on 04/28/2026

**25. Date HHA Received Signed POT**

**24. Physician's Name and Address**

Jasmin Hans
1701 Twin Springs Rd
Halethorpe, MD 21227
PHONE: 410-933-79616 FAX: 14109337666 NPI: 1497805147

**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 : 04/26/2026

**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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| Raymond Hierstetter<br>9503 HICKORY FALLS WAY,<br>NOTTINGHAM, MD 21236-<br>410-256-0109 | HomeCentris Healthcare LLC<br>10 Crossroads Drive, Suite 102<br>Owings Mills, MD 21117-8284<br>410-321-8448<br>1487113239 |

heart-healthy nutrition, and compliance with follow-up care. The patient was receptive to all instructions provided. The plan of care includes skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> at a frequency of 1 week 1, then 2 weeks 1, then 1 week 3, or as ordered, for continued assessment, medication management, disease process education, safety teaching, and monitoring of cardiopulmonary, neurological, pain, and functional status. Physical therapy and occupational therapy evaluations and treatment are ordered to address right-sided weakness, impaired balance, transfer deficits, gait dysfunction, stair negotiation, ADL performance, home safety, and fall risk reduction. A lower-extremity home exercise program was initiated, and the patient demonstrated good rehabilitation potential for skilled physical therapy to improve strength, balance, gait quality, functional mobility, endurance, and safety within the home and community environment. Continued caregiver involvement is recommended to support medication compliance, safe mobility, ADL/IADL assistance, and carryover of therapy and nursing education. <br> Date of Order 04/28/2026 Orders Physician Face-to-Face Date: 04/26/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat 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 <br> 1 - SOC - SN Notes: soc PT Eval Notes: Physician Hans, Jasmin

## SN Careplans

SN WK1: 1 (04/28/26-05/02/26) ,WK2: 2 (05/03/26-05/09/26) ,WK3: 2 (05/10/26-05/16/26) ,WK4: 1 (05/17/26-05/23/26) ,WK5: 1 (05/24/26-05/30/26) ,WK6: 1 (05/31/26-06/06/26)

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:Refused

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, limited endurance, weak hand grips, balance deficit, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises, glucose testing via monitor

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, * 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, meal preparation is available to patient for all meals

## SN Goals

PATIENT-STATED GOAL: I WANT TO GET BACK TO WORK. I AM USE TO WORKING.

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

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

meal preparation is available to patient for all meals

| Signature of Physician: | Date |
|---|---|
| | PAGE 2 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 04/28/2026 |

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## PT Careplans

PT WK1: 5 (04/28/26-05/02/26) ,WK2: 5 (05/03/26-05/09/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea, Pain Interference with Therapy activities, GG0130F1 - Upper Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, 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, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Medication management : Review medications with patient, cough/deep breathing exercises, incentive spirometer, home exercise program: Standing here , he raises hip flection , hip abduction , hip extension , hamstring curls , seated , knee extension and DF, 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, 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, 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, Upper Body Dressing - 06. Independent

## PT Goals

PATIENT-STATED GOAL: Turn prove my walking , strength and balance to be able to get off the walker drive again and get back to work

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

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

Upper Body Dressing - 06. Independent

Signature of Physician:

Date



Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

04/28/2026