Home Health Certification and Plan of Care

Order ID: 1150/18615

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6MD5KU9GC72	03/13/2026	From: 05/12/2026 To: 07/10/2026	23411	217058

6. Patient's Name and Address

Vera Wilson
2500 Belvedere Avenue Apt M1,
BALTIMORE, MD 21215-
443-803-8161

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 04/20/1959 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I69.354	Hemiplga following cerebral infrc affecting left nondom side	03/13/26

13. ICD	Other Pertinent Diagnoses	Date
I69.320	Aphasia following cerebral infarction	03/13/26
I69.322	Dysarthria following cerebral infarction	03/13/26
G40.909	Epilepsy unsp not intractable without status epilepticus	03/13/26
E11.9	Type 2 diabetes mellitus without complications	03/13/26
I10.	Essential (primary) hypertension	03/13/26
J45.909	Unspecified asthma uncomplicated	03/13/26
R13.10	Dysphagia unspecified	03/13/26
E78.5	Hyperlipidemia unspecified	03/13/26
G89.29	Other chronic pain	03/13/26
M19.90	Unspecified osteoarthritis unspecified site	03/13/26
Z79.82	Long term (current) use of aspirin	03/13/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	03/13/26

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

LACOSAMIDE 150 mg / 1 Tablet by mouth every 12 hours Give 225 mg for Seizures
Acetaminophen - Acetaminophen 500 mg / 1 Tablet by mouth every 8 hours Give 2 tablet for pain do not exceed 3 grams per day
Amlodipine Besylate - Amlodipine Besylate eq 10 mg base / 1 Tablet by mouth once a day for HTN Hold for systolic less than 110 and HR less than 50
Aspirin Ec - Aspirin 81 mg / 1 Tablet by mouth once a day for Hx of CVA
Atorvastatin Calcium - Atorvastatin Calcium 40 mg / 1 Tablet by mouth at bedtime for HLD
Metformin Hcl - Metformin Hydrochloride 500 mg / 1 Tablet by mouth every 12 hours for DM
Lisinopril - Lisinopril 20 mg / 1 Tablet by mouth once a day for HTN Hold for SBP <110
GABAPENTIN 100 mg / 1 Tablet by mouth every 12 hours for neuropathy
Scopolamine - Scopolamine 1mg/3 days transdermal as necessary Every three days if needed for nausea

14. DME and Supplies:

wheelchair, walker, hospital bed, hand held shower, 4 wheeled walker, bath bench

15. Safety Measures:

transfer with assist, walker precautions, wheelchair precautions, supervision at all times, standard precautions, medication safety, fall precautions, bedrails up while in bed, bathroom safety, aspiration precautions, ambulates with device, ambulates with assistance

16. Nutrition:

soft

17. Allergies:

no known allergies

18.A. Functional Limitations

Bowel/Bladder Incontinence, Contracture, Endurance, Speech

18.B. Activities Permitted

Wheelchair, Walker

19. Mental & Pyschosocial Status: COGNITION: 2. Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance)., ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: , MOBILITY:

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 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 an adult female who is alert and oriented to person, place, and time, though she demonstrates mild cognitive impairment characterized by forgetfulness of minor details. Her medical history is significant for a prior cerebrovascular accident resulting in left-sided hemiplegia, as well as a recent hospitalization and rehabilitation stay following a seizure. The patient previously lived alone and was independent with medication management, grooming, dressing, and bathing, and ambulated with a cane; family members assisted with meal preparation. At the time of evaluation, the patient presents with left-sided weakness, urinary incontinence, decreased safety awareness, and a decline in functional mobility and activities of daily living. She has been spending the majority of the day in bed and utilizing incontinence briefs (Depends) for toileting. During the visit, the patient required contact guard assistance to transfer to a wheelchair but demonstrated poor safety awareness by failing to lock the wheelchair brakes. She independently propelled the wheelchair to the bathroom but required minimal assistance for toilet transfer and maximal assistance for management of incontinence garments. The patient's sister, who was present during the occupational therapy evaluation, reports that the patient experienced a fall the previous day while attempting to ambulate without an assistive device to answer the door; emergency medical services were required to assist with getting the patient up, though no injuries were reported. Plans are in place to improve home access safety, including provision of an additional key for caregiver entry. The patient resides alone, with family providing intermittent support. Her sister expressed interest in becoming a paid caregiver through a Medicaid Waiver program; this request has been communicated to the clinical manager for coordination with a personal care agency. Medication reconciliation revealed that the patient is currently out of amlodipine and atorvastatin, and the family is actively working to obtain refills. Given the patient's functional decline, impaired mobility, fall risk, and need for assistance with activities of daily living, skilled occupational therapy services are indicated. The plan of care includes therapy at a frequency of once weekly for eight weeks, focusing on ADL retraining, functional mobility, therapeutic exercise, home exercise program development, neuromuscular re-education, safety training, and fall prevention strategies. Education was provided to the patient and caregiver regarding safe transfers, use of assistive devices, and the importance of supervision to reduce fall risk. Continued interdisciplinary support is recommended to optimize safety, promote independence, and prevent further decline.
 Date of Order 05/11/2026 Orders Physician Face-to-Face Date: 02/03/2026 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 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
 4 - Recertification Notes: The patient is for recert due to cervical stenosis after a fall as well as recent MVA and L ankle fracture. The patient is primarily limited due to LUE weakness that impacts ability to hold onto AD, as well as fear of falling. The patient is waiting for appt for surgical repair of cervical stenosis which she was told should be in the next few days. PT services would be beneficial following her procedure as she is too nervous to shift her spine while moving until procedure is complete.
 Physician Javillo, Jason

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/11/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Jason Javillo
2434 W Belvedere Ave
Baltimore, MD 21215
PHONE: 4106016840 FAX: 14106014029 NPI: 1366472557

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 : 02/03/2026

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 WK2: 1 (05/17/26-05/23/26) ,WK4: 1 (05/31/26-06/06/26) ,WK6: 1 (06/14/26-06/20/26) ,WK8: 1 (06/28/26-07/04/26)

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: 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

HOSPITALIZATION RISKS: 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

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: M2102d - Caregiver Performs Treatment, coughing, abnormal sputum production, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, limited endurance, impaired speech, tooth pain/decay/sensitivity, discolored patches of skin

PROCEDURES: MEDICATION REVIEW: Medications reviewed with patient or caregiver. , Assess left hip boils: if skin open to call pcp, cough/deep breathing exercises, coordinate/arrange access to medicine/medical supplies considering patient inability to pay

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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) 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 self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule, patient's transportation needs are met, patient's living environment is clean/uncluttered, patient has access to medicine/medical supplies considering inability to pay, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, MEDICATION REVIEW

PATIENT-STATED GOAL: I want this pain to go away on my left hip (from the boils)

GOALS
patient has access to medicine/medical supplies considering inability to pay

patient's transportation needs are met

patient's living environment is clean/uncluttered

patient is adequately supervised

meal preparation is available to patient for all meals

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
* 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) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

MEDICATION REVIEW

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

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

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

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

Signature of Physician:

Date

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

Date
05/11/2026