Home Health Certification and Plan of Care

Order ID: 1150/18616

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
83125291	05/12/2026	From: 05/12/2026 To: 07/10/2026	25736	217058

6. Patient's Name and Address
Philip Amoatin
8395 Tamar Drive Apt 225,
COLUMBIA, MD 21045-
508-714-1472

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 02/05/1956 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I69.351	Hemiplga following cerebral infrc aff right dominant side	05/12/26

13. ICD	Other Pertinent Diagnoses	Date
I69.320	Aphasia following cerebral infarction	05/12/26
I10.	Essential (primary) hypertension	05/12/26
E11.9	Type 2 diabetes mellitus without complications	05/12/26
E78.49	Other hyperlipidemia	05/12/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	05/12/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	05/12/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	05/12/26
Z79.82	Long term (current) use of aspirin	05/12/26
Z91.81	History of falling	05/12/26

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

AMLODIPINE 10 mg / 1 Tablet by mouth one time a day for HTN
ASPIRIN Chewable 81 mg / 1 Tablet by mouth one time a day for CVA Prophylaxis
ATORVASTATIN 80 mg / 1 Tablet by mouth at bedtime for Hyperlipidemia
FLOMAX 0.4 mg/capsule / Give 2 capsule by mouth at bedtime for BPH
GLIPIZIDE 10 mg/tablet / Give 2 tablet by mouth two times a day for DM
JARDIANCE 10 mg / 1 Tablet by mouth one time a day for DM
LOSARTAN POTASSIUM 100 mg / 1 Tablet by mouth one time a day for HTN
METFORMIN 1000 mg / 1 Tablet by mouth two times a day for DM
Metoprolol Tartrate - Metoprolol Tartrate 50 mg / 1 Tablet by mouth one time a day for HTN
Plavix - Clopidogrel Bisulfate 75 mg / 1 Tablet by mouth one time a day for Acute stroke due to embolism of unspecified artery

14. DME and Supplies:
rolling walker, walker, diabetic supplies, bath bench, 4 wheeled walker

15. Safety Measures:
standard precautions, transfer with assist, walker precautions, sharps precautions, infectious material management, medication safety, fall precautions, bathroom safety, activity supervision, ambulates with assistance, ambulates with device, anticoagulant precautions, aspiration precautions

16. Nutrition:
soft, diabetic, cardiac diet

17. Allergies:
simvastatin

18.A. Functional Limitations
Endurance, Speech, Ambulation

18.B. Activities Permitted
Walker, , Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 1. Rarely, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required, 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

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 70-year-old male with a significant past medical history of cerebrovascular accident (CVA) with residual right-sided flaccid hemiplegia, basal ganglia infarct with residual ataxic gait, aphasia with slurred speech, hypertension (HTN), type 2 diabetes mellitus (DM2), hyperlipidemia (HLD), benign prostatic hyperplasia (BPH), recurrent falls, and impaired functional mobility. The patient was initially evaluated at a Kaiser clinic after presenting with difficulty ambulating and was subsequently diagnosed with a CVA resulting in right-sided weakness, facial droop, aphasia, impaired coordination, and gait instability. Following hospitalization and subsequent skilled acute rehabilitation stay, the patient continues to demonstrate significant functional deficits requiring ongoing skilled home health services. The patient resides in an apartment with his two sons and requires assistance with communication due to expressive aphasia and difficulty speaking. The apartment building includes approximately 8-10 steps for access, further complicating mobility and safety. On assessment, the patient demonstrated residual right-sided weakness with gross motor strength approximately 4/5 in the right upper and lower extremities, although lower extremity strength fluctuates between 2+/5 to 3+/5 during functional mobility tasks. The patient exhibits right-sided facial droop, impaired motor planning, decreased coordination, reduced balance reactions, and ataxic gait mechanics. The patient ambulates indoors with or without a rolling walker while utilizing furniture and walls for stabilization and requires a rolling walker for outdoor ambulation along with caregiver supervision for safety. Transfers and household mobility remain impaired due to weakness, decreased dynamic balance, gait instability, and impaired safety awareness, placing the patient at elevated risk for falls. Additional deficits include reduced right hand function, impaired coordination, decreased performance with basic and instrumental activities of daily living (BADLs/IADLs), reduced swallowing function with aspiration concerns, and expressive aphasia following cerebral infarction. The patient is considered homebound due to the taxing effort required to safely leave the home secondary to impaired gait, residual neurological deficits, aphasia, decreased endurance, and need for assistive device and human assistance for ambulation. During the visit, the patient was noted to have elevated blood pressure but remained asymptomatic. Kaiser was notified regarding the elevated blood pressure, and the family was instructed to have the patient evaluated at a Kaiser facility for further assessment. Education was provided to the patient and family regarding fall prevention, safe use of the rolling walker, mobility safety, and the importance of monitoring blood pressure and neurological symptoms. Skilled home health physical and occupational therapy services are medically necessary to address gait training, balance retraining, strengthening, coordination, motor planning, transfer training, upper extremity functional use, ADL performance, fall prevention, and overall safety to maximize functional independence and reduce risk for further decline or rehospitalization within the home environment.
 Date of Order 05/12/2026 Orders Physician Face-to-Face Date: 05/07/2026 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
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Digen, Beatrice

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/12/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Beatrice Digen
12201 Plum Orchard Dr
Silver Spring, MD 20904
PHONE: 3015721000 FAX: NPI: 1114344165

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 : 05/07/2026

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 Careplans

SN WK1: 1 (05/12/26-05/16/26) ,WK2: 2 (05/17/26-05/23/26) ,WK3: 1 (05/24/26-05/30/26) ,WK5: 1 (06/07/26-06/13/26) ,WK7: 1 (06/21/26-06/27/26) ,WK9: 1 (07/05/26-07/10/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 4. Multiple emergency department visits (2 or more) in the past 6 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; 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 ; 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.

Pagient did. Not have surgery, rn unable to remove No surgery please remove
Advance Directive:Family member requesting to attempt cpr

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M2020 - Oral Med Management, Home Safety, M2102f - Patient Supervision, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, abnormal blood pressure, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, limited strength, limited endurance, limited range of motion, impaired speech, balance deficit

PROCEDURES: MEDICATION REVIEW: Patient and caregiver verbalized understanding of medication and medication schedule. Ensure no changes or additions to medications,, cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, 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, * 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, MEDICATION REVIEW

SN Goals

PATIENT-STATED GOAL: Patient has Aphasia, from son, dad would want to be as independent as prior to the stroke

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
* 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

patient's living environment is clean/uncluttered

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

MEDICATION REVIEW

PT Careplans

PT Goals

Signature of Physician:

Date

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

Date
05/12/2026

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PT WK1: 5 (05/12/26-05/16/26) ,WK2: 5 (05/17/26-05/23/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet 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, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Balance and coordination Training: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet 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, Car Transfer - 05. Setup or clean-up assistance

PATIENT-STATED GOAL: To have a successful post stroke recovery

GOALS
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

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

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

Car Transfer - 05. Setup or clean-up assistance

OT Careplans

OT WK1: 1 (05/12/26-05/16/26) ,WK2: 1 (05/17/26-05/23/26) ,WK3: 1 (05/24/26-05/30/26) ,WK4: 1 (05/31/26-06/06/26) ,WK5: 1 (06/07/26-06/13/26) ,WK6: 1 (06/14/26-06/20/26) ,WK7: 1 (06/21/26-06/27/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing

PROCEDURES: Home exercise program : exe recommended for home, Therapeutic exercise : exe during the visit, Medication review : med list, Improve hand function : improve hand sterngthen and dextrity, cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation

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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, 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 do tub transfers

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

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

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	05/12/2026