Home Health Certification and Plan of Care

Order ID: 1150/19994

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
100149138	06/21/2026	From: 06/21/2026 To: 08/19/2026	20498	217058

6. Patient's Name and Address
Michael Yerby
6512 Langdale Rd,
ROSEDALE, MD 21237-
410-564-6770

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 11/20/1975 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I69.854	Hemiplga fol oth cerebvasc disease aff left nondom side	06/21/26

13. ICD	Other Pertinent Diagnoses	Date
I69.822	Dysarthria following other cerebrovascular disease	06/21/26
E11.9	Type 2 diabetes mellitus without complications	06/21/26
I10.	Essential (primary) hypertension	06/21/26
E78.49	Other hyperlipidemia	06/21/26
I95.1	Orthostatic hypotension	06/21/26
I82.412	Acute embolism and thrombosis of left femoral vein	06/21/26
F33.2	Major depressv disorder recurrent severe w/o psych features	06/21/26
J45.998	Other asthma	06/21/26
F17.200	Nicotine dependence unspecified uncomplicated	06/21/26
K31.1	Adult hypertrophic pyloric stenosis	06/21/26
K44.9	Diaphragmatic hernia without obstruction or gangrene	06/21/26
Z86.711	Personal history of pulmonary embolism	06/21/26
Z79.01	Long term (current) use of anticoagulants	06/21/26
Z79.82	Long term (current) use of aspirin	06/21/26

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

Escitalopram - Escitalopram Oxalate 20 MG tablet by mouth daily with dinner Take 1 tablet (20 mg total)
Baclofen - Baclofen 10 MG tablet by mouth 2 (two) times daily Take 1 tablet (10 mg total)
Atorvastatin Calcium - Atorvastatin Calcium 80 mg by mouth once a day
Metformin - Metformin Hydrochloride 1 tablet by mouth before meal Hcl er 500 mg
Gabapentin - Gabapentin 100 mg 1 tablet by mouth three times a day
Dabigatran Etexilate - Dabigatran Etexilate 1 tablet by mouth twice a day 150 mg
Pantoprazole - Pantoprazole Sodium 40 mg EC tablet Oral daily Take 1 tablet (40 mg total)
Actoplus - Metformin Hydrochloride: Pioglitazone Hydrochloride 500 MG 24 hr tablet Oral daily with dinner Take 1 tablet (500 mg total)
Risperdal - Risperidone 1 MG tablet Oral nightly Take 1 tablet (1 mg total)

14. DME and Supplies:
wheelchair, rolling walker, diabetic supplies, walker, , commode, cane, 4 wheeled walker

15. Safety Measures:
fall precautions, diabetic precautions, bleeding precautions, ambulates with device, medication safety, smoke detectors , walker precautions, transfer with assist, supervision at all times, ambulates with assistance, wheelchair precautions, standard precautions, , cardiac precautions, bathroom safety, anticoagulant precautions, activity supervision

16. Nutrition:
diabetic,

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Speech, Bowel/Bladder Incontinence, Dyspnea With Minimal Exertion, Ambulation

18.B. Activities Permitted
Up As Tolerated, Exercises Prescribed, Wheelchair, Transfer bed/Chair

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 0. Never, 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!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions!3. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.!5. Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions), 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 other cerebrovascular disease 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 a 50-year-old male referred to home health services following a recent hospitalization and subsequent skilled nursing facility/short-term rehabilitation stay for a right cerebrovascular accident (CVA) resulting in left hemiparesis and dysarthria. His past medical history is significant for a previous CVA in 2023, diabetes mellitus, hypertension, hyperlipidemia, left lower extremity deep vein thrombosis (DVT), asthma, depression, and tobacco use. The patient reported limited functional progress during his rehabilitation stay. Prior to his recent stroke, he was independent with basic self-care activities, functional transfers, and household ambulation using a small-base quad cane, and was able to negotiate stairs with modified independence. Following discharge, the patient is temporarily residing in his sister's home while the family seeks a handicap-accessible residence. His bedroom is currently located in the basement, and he was transported home by ambulance. He receives assistance from daytime and nighttime caregivers, as his sister works during the day. The patient is a full code, and all prescribed medications are available in the home. The patient is currently bedbound and requires total assistance for mobility and most activities of daily living. He presents with significant left-sided hemiparesis, dysarthria, decreased upper extremity strength, impaired sitting and standing balance, reduced standing tolerance, decreased activity tolerance, impaired bed mobility, and severely limited transfer and gait abilities. He is unable to safely transfer to his wheelchair or ambulate, despite having both a wheelchair and walker available, due to profound weakness and poor balance, placing him at high risk for falls. During the assessment, the patient complained of left knee pain and right wrist pain, for which lidocaine patches were applied with the goal of providing pain relief. Physical therapy assessment revealed the patient required moderate to maximal assistance for bed mobility, maximal assistance for sit-to-stand transfers, and maximal assistance for stand-pivot transfers using a small-base quad cane. Ambulation was not recommended outside of skilled therapy sessions because of his significant fall risk and impaired functional mobility. Clonus was observed in the left lower extremity during dorsiflexion, and the patient and caregivers were instructed on the use of joint approximation techniques to reduce clonus. Education was also provided to the caregivers and nephew regarding safe rolling techniques, supine-to-sit transitions, sit-to-stand transfers, stand-pivot transfer techniques, proper hand and foot placement, lower extremity therapeutic exercises, and the recommendation to obtain and utilize a gait belt for safer transfers. The patient's neurological deficits significantly impair his ability to perform self-care, bed mobility, functional transfers, balance activities, and ambulation, resulting in complete dependence on caregivers for daily care. Skilled physical therapy is

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/21/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Rachel Purser
1000 E Eager St
Baltimore, MD 21202
PHONE: 4106246068 FAX: 14103420267 NPI: 1982333233

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 : 06/15/2026

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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medically necessary to address deficits in strength, balance, transfer training, gait training, functional mobility, neuromuscular re-education, fall prevention, and caregiver training with the goal of maximizing functional mobility and reducing caregiver burden. Skilled occupational therapy is also medically necessary to improve upper extremity strength and function, activity tolerance, sitting and standing balance, self-care performance, and functional transfer abilities, while providing adaptive strategies and caregiver education to maximize the patient's independence, safety, and quality of life and to prevent further functional decline and rehospitalization. Skilled nursing services are indicated for ongoing disease management, comprehensive assessment, medication management, pain management, neurological monitoring, caregiver education, and coordination of care to support the patient's complex medical needs in the home setting.
 Date of Order 06/21/2026 Orders Physician Face-to-Face Date: 06/15/2026 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 other cerebrovascular disease 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
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Purser, Rachel

SN Careplans

SN WK1: 1 (06/21/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26) ,WK3: 1 (07/05/26-07/11/26) ,WK4: 1 (07/12/26-07/18/26) ,WK5: 1 (07/19/26-07/25/26) ,WK6: 1 (07/26/26-07/30/26)

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), 3. Multiple hospitalizations (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 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, 8. Currently reports exhaustion

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: M1745 - Behavioral Issues, D0160 - Depression, M1700 - Cognition, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, M1400 - Dyspnea, dependent edema, M1033 - Exhaustion, M1620 - Bowel Incontinence, M1610 - Urinary Incontinence, muscle weakness, limited range of motion, poor muscle tone, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, weak hand grips, daytime fatigue, balance deficit, difficulty sleeping, lethargy, impaired speech

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental

SN Goals

PATIENT-STATED GOAL: Caregiver states she wants her brother to be able to walk again using his walker.

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
* 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

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) purpose, schedule

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/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

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/21/2026

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coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, bladder training, teach/coordinate/arrange medication packaging and/or administration

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, * how to keep home safe for patient with dementia coping strategies for the caregiver*, 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, * 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 self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (06/21/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26) ,WK3: 2 (07/05/26-07/11/26) ,WK4: 1 (07/12/26-07/18/26) ,WK5: 1 (07/19/26-07/25/26)

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, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface

PROCEDURES: Sitting balance : Ed wt shifting outside bos rhythmic stabilization of trunk, Medication management : Reviewed medication with caregiver, Wc negotiation : Ed pt amd caregiver on negot wc using RUE AND LE, home exercise program: Le stretching hamstring, knn flexion, gatroc stretching 20 sec holds x4 each, lle aarom all planes, supine bridging, saq, Heelslides, hip and add, seated hip flexion laq, heelraises, aps, df as tolerated, equipment training: Trg negot wc using RUE AND RLE ON LOWER LEVEL, gait training/stair training: Work short distance amb using sbqc, gait belt close wc follow, transfers training: Ed trg proper mechanics, use of wc and or sbqc

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 - 03. Partial/moderate assistance, Walk 10 Feet - 04. Supervision or touching assistance, Wc negotiation

PT Goals

PATIENT-STATED GOAL: He reported to walk again stand on his own get stronger

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

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

Toilet Transfer - 03. Partial/moderate assistance

Walk 10 Feet - 04. Supervision or touching assistance

Wc negotiation

OT Careplans

OT WK1: 1 (06/21/26-06/27/26) ,WK3: 1 (07/05/26-07/11/26) ,WK5: 1 (07/19/26-07/25/26) ,WK7: 1 (08/02/26-08/08/26) ,WK9: 1 (08/16/26-08/19/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating

PROCEDURES: Medication Review : Medication reviewed with patient with all medications in the home, home exercise program: AAROM bilateral UE with focus on left UE. Shoulder raises, biceps curls, forearm pronation, forearm supination, equipment training, work simplification/energy conservation, transfers training: Skilled OT, assist with bathing: Skilled OT, assist with toileting hygiene: Skilled OT, assist with grooming: Skilled OT, assist with lower body dressing: Skilled OT, assist with upper body dressing: Skilled OT

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, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent

OT Goals

PATIENT-STATED GOAL: Get in the shower

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
* 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

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/21/2026