Home Health Certification and Plan of Care

Order ID: 1150/18009

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
36243938	04/16/2026	From: 04/16/2026 To: 06/14/2026	16458	217058

6. Patient's Name and Address
William Tyler
3214 Carlswood Circle,
WINDSOR MILL, MD 21244-
443-596-1550

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 01/19/1950 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I65.21	Occlusion and stenosis of right carotid artery	04/16/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	04/16/26
E11.9	Type 2 diabetes mellitus without complications	04/16/26
E78.5	Hyperlipidemia unspecified	04/16/26
Z79.82	Long term (current) use of aspirin	04/16/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	04/16/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	04/16/26

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

Colace - Docusate Sodium 100 mg, Take (100 mg) Capsule by mouth twice a day
Multi Vitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tab by mouth once a day supplement
Cozaar - Losartan Potassium 100 mg 100 mg , take (100 mg) Tablet by mouth once a day HTN
Pravachol - Pravastatin Sodium 40 mg 40 mg , take (40 mg) tablet by mouth at bedtime CHOLESTEROL
Pioglitazone - Pioglitazone Hydrochloride 30 mg 30 mg; 1 TAB by mouth in the morning DM
Asa 81 Mg - Aspirin 81MG; 1 TAB by mouth once a day PROPHYLACTIC
Lantus - Insulin Glargine Recombinant 100 units/ml 30UNITS by mouth once a day DM
Coreg - Carvedilol 25 mg 25MG; 1 Tablet by mouth twice a day HTN

14. DME and Supplies:
diabetic supplies, bath bench, walker, cane

15. Safety Measures:
standard precautions, fall precautions, diabetic precautions, ambulates with device, walker precautions, medication safety, sharps precautions, anticoagulant precautions

16. Nutrition:
cardiac diet, diabetic

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation, LEFT SIDED WEAKNESS

18.B. Activities Permitted
Cane, 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: 2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, 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

Homebound status: Due to diagnosis of Occlusion and stenosis of right carotid artery, 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 76-year-old male recently discharged from Levindale Specialty Hospital following hospitalization on 03/20/2026 for a cerebrovascular accident (CVA) involving a small infarct in the posterior right frontal lobe, resulting in left-sided weakness. His past medical history is significant for hypertension, hyperlipidemia, and poorly controlled diabetes mellitus, with a most recent hemoglobin A1c of 12.2%. The patient resides at home with his daughter, who provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. Skilled nursing services have been initiated with a planned frequency of once weekly for 12 weeks, followed by two additional weekly visits and one final visit. Physical and occupational therapy evaluations have been ordered. The patient is currently monitoring fingerstick blood glucose levels twice daily. On assessment, the patient is alert and oriented to person, place, and time. He denies pain and shortness of breath, and lung sounds are clear throughout. He reports a good appetite, with last bowel movement occurring the previous day. Fingerstick blood glucose was recorded at 128 mg/dL. Bilateral lower extremities demonstrate trace edema. The patient ambulates with the use of a quad cane for safety. Medication reconciliation was completed, and the patient was instructed on medication names, dosages, frequencies, and potential side effects. Education was also provided regarding diabetes management and the importance of glycemic control in relation to stroke recovery, as well as initial teaching on CVA, including risk factors and prevention strategies. The patient was receptive to all education provided. Physical therapy evaluation completed on 04/09/2026 indicates the patient presents with minimal residual deficits following CVA, including mild left-sided weakness graded at approximately 4+/5 and impaired dynamic standing balance requiring contact guard assistance, particularly on narrow base or uneven surfaces. No significant range of motion limitations or pain were noted. The patient demonstrates independent and steady transfers and is able to ambulate greater than 100 feet on level surfaces without an assistive device, although he utilizes a quad cane for added safety. Vital signs were stable at the time of evaluation. Skilled physical therapy services are indicated to address dynamic balance deficits, improve lower extremity strength, enhance gait safety, and implement a structured home exercise program, along with fall prevention strategies. Caregiver education and training will also be provided to support safe mobility and progression toward modified independence in both household and community settings.
 Date of Order 04/16/2026 Orders Physician Face-to-Face Date: 04/03/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Occlusion and stenosis of right carotid artery 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 Nkwanyuo, Joseph

SN Careplans

SN WK1: 1 (04/16/26-04/18/26) ,WK2: 1 (04/19/26-04/25/26) ,WK3: 2 (04/26/26-05/02/26) ,WK4: 1 (05/03/26-05/09/26)

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: 5. Decline in mental, emotional, or behavioral status in the past 3 months,

SN Goals

PATIENT-STATED GOAL: I WANT TO DO THE RIGHT THINGS TO GET BETTER

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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 04/16/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Joseph Nkwanyuo
8930 Liberty Road
Randallstown, MD 21133
PHONE: 4102657742 FAX: 14102983964 NPI: 1194805036

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 : 04/03/2026

27. Attending Physician's Signature and Date Signed **06/30/2026**: 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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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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, limited strength, limited endurance, balance deficit

PROCEDURES: cough/deep breathing exercises

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, * 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

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
* 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

PT Careplans

PT WK1: 1 (04/16/26-04/18/26) ,WK2: 1 (04/19/26-04/25/26) ,WK3: 1 (04/26/26-05/02/26) ,WK5: 1 (05/10/26-05/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170G1 - Car Transfer, 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, 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: HEP: Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., Medication Review-: Patient verbalized understanding of current prescriptions, dosages, and schedule. No reported issues with adherence, side effects, or confusion at this time., B LE strengthening: 1, Dynamic Standing balance Training: 1, home exercise program, gait training/stair training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: not to go back to hospital

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Signature of Physician:

Date

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

Date
04/16/2026

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Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

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	04/16/2026