Home Health Certification and Plan of Care

Order ID: 1150/20979

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
30522151750	07/30/2026	From: 07/30/2026 To: 09/27/2026	27971	217058

6. Patient's Name and Address
Denise Matthews
537 Richwood Avenue,
BALTIMORE, MD 21212-
443-271-3913

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 01/05/1975 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I10.	Essential (primary) hypertension	07/30/26

13. ICD	Other Pertinent Diagnoses	Date
E28.2	Polycystic ovarian syndrome	07/30/26
D25.9	Leiomyoma of uterus unspecified	07/30/26
I69.354	Hemiplga following cerebral infrc affecting left nondom side	07/30/26
Z86.79	Personal history of other diseases of the circulatory system	07/30/26

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

Amlodipine Besylate - Amlodipine Besylate 10 MG / 1 Tablet by mouth once a day for HTN Hold for SBP less than 110 or HR less than 60
CARVEDILOL 12.5 MG / 1 Tablet by mouth twice a day for HTN Hold for SBP less than 110 or HR less than 60
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) MG / 1 Tablet by mouth once a day every other day for Supplement
GABAPENTIN 400 MG / 1 Capsule by mouth three times a day for Neuropathy
LISINOPRIL 40 MG / 1 Tablet by mouth once a day for HTN Hold for SBP less than 110 OR HR less than 60
SENNA 8.6 mg/tablet / Give 2 tablet by mouth twice a day for Bowel regimen
Tylenol Es 500 Mg - Acetaminophen Give 2 tablet by mouth every 8 hours for Pain Management
Diclofenac Sodium - Diclofenac Sodium External Gel 1 % / Apply 4 gms to B knees topical as necessary every 6 hours for Pain
Lidocaine Patch - Lidocaine 5 % / Apply to L thigh topical once a day for Pain and remove per schedule

14. DME and Supplies:
hospital bed, walker, wheelchair, bath bench

15. Safety Measures:
standard precautions, fall precautions, medication safety, wheelchair precautions, walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with assistance, ambulates with device

16. Nutrition:
soft

17. Allergies:
latex penicillin

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Wheelchair, Transfer bed/Chair, Exercises Prescribed, 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: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: good

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
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Essential (primary) hypertension, 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 51-year-old female admitted to skilled home health services following hospitalization and subsequent subacute rehabilitation. Her past medical history is significant for nontraumatic intracerebral hemorrhage with residual left-sided deficits, brain compression, protein-calorie malnutrition, hypertension, dysphagia, and leiomyoma of the uterus. The patient is now residing at home with her daughter and spouse, who serve as her primary caregivers and provide assistance with activities of daily living (ADLs), mobility, and other care needs. The patient is alert and oriented 3, and vital signs were assessed and found to be within normal limits. Skin assessment revealed no current wounds, pressure injuries, or areas of skin breakdown. Medication reconciliation was completed, and comprehensive education was provided regarding medication management, adherence, and the importance of taking medications as prescribed. Additional education focused on fall prevention and home safety, including the proper use of assistive devices, maintaining a clutter-free environment, and utilizing caregiver assistance during ambulation and transfers. Pressure injury prevention was also reinforced through instruction on frequent repositioning, offloading pressure areas, maintaining adequate nutrition and hydration, and routinely monitoring the skin for redness or breakdown. Both the patient and caregivers verbalized understanding of all education provided. The patient continues to require skilled nursing services for ongoing comprehensive assessment, medication management and education, monitoring for complications related to her chronic medical conditions, skin integrity surveillance, fall prevention, and continued patient and caregiver education to promote safety and prevent rehospitalization. An occupational therapy evaluation was completed following the patient's hospitalization and subacute rehabilitation. Prior to her illness, the patient was independent with basic self-care activities, functional transfers, and household ambulation without the use of an assistive device. Since her intracerebral hemorrhage, the patient demonstrates significant functional decline characterized by impaired standing balance, decreased standing tolerance, reduced bilateral upper extremity strength, diminished activity tolerance, and impaired functional mobility, resulting in decreased independence with self-care tasks, functional transfers, and ambulation. The patient currently requires the use of a walker with caregiver assistance for mobility or a wheelchair for longer distances due to her mobility limitations and residual left-sided deficits. Skilled occupational therapy services are medically necessary to address deficits in strength, balance, endurance, functional mobility, transfer techniques, and performance of ADLs, with the goal of maximizing safety, reducing caregiver burden, improving functional independence, and facilitating the patient's return to her highest attainable level of function within the home environment.
 Date of Order 07/30/2026 Orders Physician Face-to-Face Date: 06/16/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management PT-eval & treat OT-eval & treat due to Essential (primary) hypertension 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 OT Eval Notes:
 Physician Aarabi, Bizhan

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 07/30/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Bizhan Aarabi
22 S. GREENE STREET
BALTIMORE, MD 21201
PHONE: 410-328-7371 FAX: 14103281420 NPI: 1174578876

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 : 06/16/2026

27. Attending Physician's Signature and Date Signed **08/05/2026**: 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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Denise Matthews 537 Richwood Avenue, BALTIMORE, MD 21212- 443-271-3913	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

SN WK1: 1 (07/30/26-08/01/26) ,WK2: 1 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26) ,WK6: 1 (08/30/26-09/05/26) ,WK7: 1 (09/06/26-09/12/26)

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: 3. Multiple hospitalizations (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; 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:Patient would like to be full code

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, M2102f - Patient Supervision, meal preparation, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, muscle weakness, limited range of motion, limited endurance, limited strength, weak hand grips, balance deficit

PROCEDURES: teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, 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

PATIENT-STATED GOAL: Patient stated she would like to remain free of fall and regain strength

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

patient's transportation needs are met

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

OT Careplans

OT WK1: 1 (07/30/26-08/01/26) ,WK3: 1 (08/09/26-08/15/26) ,WK5: 1 (08/23/26-08/29/26) ,WK7: 1 (09/06/26-09/12/26) ,WK9: 1 (09/20/26-09/26/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, 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, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Medication Review : Medication reviewed with patient and caregiver with

OT Goals

PATIENT-STATED GOAL: Walk better

GOALS
Toilet Transfer - 06. Independent

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/30/2026

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all medications in the home, home exercise program: AAROM addressing left UE shoulder flexion,,abduction, abduction, elbow flexion, extension, 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 - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet 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, Car Transfer - 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, Eating - 06. Independent, Upper Body Dressing - 06. Independent

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 - 05. Setup or clean-up assistance

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

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

Car Transfer - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
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