HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022042

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
53707139500	09/11/2026	09/11/2026 - 11/09/2026	29945	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Dolores Dela Pena 6712 Baythorne Rd BALTIMORE, MD 21209	Female	02/22/1945	4439291791
	Email		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI: 1487113239		Fax Number: 410-559-3002

Clinical Condition Requiring Homecare:

Start-of-care assessment completed for an 81-year-old female with a medical history of asthma, hypertension, hypothyroidism, vitamin D deficiency, recurrent falls, and recent left MCA cerebrovascular accident (CVA) resulting in right-sided weakness/hemiplegia, facial droop, and aphasia. Patient has a G-tube intact to the left abdomen following EGD on 7/23/2026; no discomfort or pain reported, and the tube is currently not being used for nutrition or medication administration as patient is tolerating oral intake, with medications given in applesauce. All medications were present in the home except thyroid medication, which the daughter planned to obtain from the pharmacy. Medication reconciliation and education were completed with caregivers, including medication purpose, frequency, and potential side effects. Patient lives with her daughter, Marissa Aposaga, who is her caregiver and POA; daughter Mailia is temporarily providing care while Marissa travels to Canada. Caregivers report a good appetite, with two bowel movements yesterday and no abdominal discomfort or bleeding. Patient experiences sleep disturbance related to frequent urination. She communicates with limited verbal responses due to aphasia and has difficulty expressing herself despite understanding some English. Patient requires assistance with mobility and uses a wheelchair, cane, rollator, and walker; a hospital bed is pending delivery, and she is currently sleeping with her daughter for safety. Patient requires one-person assistance and a walker for safe ambulation, and leaving the home is a taxing effort due to impaired mobility, weakness, and history of falls. During the assessment, patient was able to stand with moderate assistance for G-tube evaluation. Caregiver will schedule a PCP follow-up for further evaluation and referral for G-tube management/removal. PT and OT services were ordered. PT evaluation revealed bilateral lower-extremity weakness at 3/5 strength, decreased endurance, and the need for contact guard assistance during ambulation with a rolling walker; prior to hospitalization, patient was independently ambulatory indoors with a single-point cane

Physician Statement on Homebound Status:

Due to diagnosis of Aphasia following cerebral infarction, 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

and outdoors with a rolling walker. Patient would benefit from continued skilled PT to improve strength, endurance, balance, and safety with functional mobility and to facilitate return toward her prior level of function. Skilled nursing is ordered at 1 visit weekly for 4 weeks, followed by 1 visit weekly for 2 weeks. Medicaid is the primary insurance, and required LTSS electronic clock-in/clock-out procedures were reviewed and followed.<o:p></o:p>

Date of Order<o:p></o:p>
09/11/2026<o:p></o:p>
Physician Face-to-Face Date:
08/14/2026<o:p></o:p>
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's dx: Aphasia following cerebral infarction<o:p></o:p>
Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>

1 - SOC - SN Notes: <o:p></o:p>
PT Eval Notes:<o:p></o:p>
Physician: Friedman, Jessica<o:p></o:p>

Due to diagnosis of Aphasia following cerebral infarction, 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<o:p></o:p>

ICD-10 CM Principal Diagnosis: I69.320. Aphasia following cerebral infarction

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
I69.351	Hemiplga following cerebral infrc aff right dominant side	Tylenol - Acetaminophen 325 mg (2 tablets) by mouth as necessary As needed for pain Albuterol Inhaler - Albuterol 90mcg inhalant every 8 hours As needed for shortness of breath Aspirin 81Mg - Aspirin 81mg by mouth once a day Atorvastatin - Atorvastatin Calcium 40mg by mouth in the evening HLD Vit D - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000u by mouth once a day Supplements Plavix - Clopidogrel Bisulfate eq 75 mg base 75mg by mouth twice a day Anti platelets Protonix - Pantoprazole Sodium eq 40 mg base 40mg by mouth once a day GERD Levothroxine - Levothyroxine Sodium 77mcg by mouth at bedtime Hypothyroidism Cozaar - Losartan Potassium 25 mg 12.5mg (half tab) by mouth twice a day Cardiac Coreg - Carvedilol 12.5 mg 12.5mg by mouth once a day Cardiac
E03.9	Hypothyroidism unspecified	
I10.	Essential (primary) hypertension	
J45.998	Other asthma	
E55.9	Vitamin D deficiency unspecified	
E78.2	Mixed hyperlipidemia	
E83.42	Hypomagnesemia	
F39.	Unspecified mood [affective] disorder	
Z91.81	History of falling	

Prognosis
good

Mental and Psychosocial 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: 1. In new or complex situations only, 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, HISTORY OF

	DEPRESSION: No
Functional Limitations Bowel/Bladder Incontinence, Dyspnea With Minimal Exertion, Ambulation, Endurance	**Activities Permitted** Walker, Wheelchair, Cane, Up As Tolerated
DME & Supplies cane, rolling walker, wheelchair, walker	**Safety Measures** smoke detectors , emergency phone # clearly displayed, aspiration precautions, transfer with assist, cardiac precautions, anticoagulant precautions, wheelchair precautions, walker precautions, standard precautions, supervision at all times, medication safety, fall precautions, bathroom safety, bleeding precautions, ambulates with device, ambulates with assistance, activity supervision
Nutrition G-Tube, low sodium, low cholesterol	**Allergies** lisinopril

Advance Directives
Marissa 443 379 1515

Caregiver Status
2. Non-agency caregiver(s) need training/supportive services to provide assistance; 2. Non-agency caregiver(s) need training/supportive services to provide assistance

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.

DISCHARGE PLAN:
SN and PT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

PT Eval

OT Eval

SN CAREPLAN

SN frequency WK1: 1 (09/11/26-09/12/26),WK2: 1 (09/13/26-09/19/26),WK3: 1 (09/20/26-09/26/26),WK4: 1 (09/27/26-10/03/26),WK5: 1 (10/04/26-10/10/26),WK6: 1 (10/11/26-10/17/26)

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: 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.

Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Advance Directive:Marissa 443 379 1515

09/17/2026 Problems : #1 - Other - Other - Left abdomen G tube - G tube site
cough/gag/pain chew/swallow (GI)
daytime fatigue (NR)
increased urine output (GU)

SN NARRATIVE

Medicaid patient must clock in and out using LTSS App

Start time 10:50 am

SOC

Medication management with ambulation dysfunction with history of Falls with history of right dominant hemiplegia and aphasia with peg tube intact requires one person assist and walker for ambulatory safety making it a taxing effort to leave the home.

PATIENT lives with daughter Marissa Aposaga caregiver and POA. Daughter Mailia is currently caregiver from Canada for the next week, Marissa leaving for Canada for class reunion. Patient is a 81yo woman from the Phillipines female with past medical history of asthma, history of falls, HTN, hypothyroidism, Vitamin D def, Rightside weaknessz face droop, aphasia, left MCA and CVA. EDG 7/23/26 with G tube left abdomen. No discomfort reported. Patient denies pain. Medications reviewed with caregivers for understanding of medications actions, frequency and side effects of each medication. All medications in the home except for thyroid medication. Prescriptions to be taken to be filled by daughter today. Patient PCP is Jessica at Chase Brexton 410 827 2050. Daughter will schedule patient for follow up visit for evaluation and referral for GTube management. Caregivers reports patient oral intake with foods. Medications taken when applesauce. G tube intact and not used for intake. Assistive devices in the home wheelchair, cane, ROLLATOR and walker. Awaiting hospital bed delivery. Patient currently sleeping in the bed with daughter for safety. Patient able to stand with moderate assistance for g tube check. Patient from a small area in the Philippines and native language is specific to area. Patient able to understand English but due to aphasia not able to respond correctly with thumbs up for yes or good. Caregiver reports patient has good appetite. Last bowel movement was yesterday x2. No abdominal discomfort reported. Caregivers reports patient has sleep disturbance due to frequency with urination. No bleeding reported. Medicaid is primary insurance. LTSS punch in and out. PT and OT ordered. SN frequency 1w4 1w2

SN GOALS

PATIENT-STATED GOAL: To get strength back

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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

M1700 - Cognition M1720 - Anxiety M1745 - Behavioral Issues Pain Interference with ADLs M1400 - Dyspnea M2020 - Oral Med Management abnormal blood pressure abn cholesterol > 200 mg/dL difficulty sleeping weak hand grips balance deficit muscle weakness limited strength limited endurance heartburn/indigestion abnormal thyroid <> 0.40 - 4.50 mIU/mL meal preparation M2102c - Med Admin M2102f - Patient Supervision M2102d - Caregiver Performs Treatment M1610 - Urinary Incontinence PROCEDURES: physician-ordered wound care: #1 - Other - Other - Left abdomen G tube - G tube site: No active orders, cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, monitor intake & output, 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, * 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver*, 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, 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/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 self-administers medications as prescribed * recalls related medication(s) purpose, schedule 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 NARRATIVE Medicaid patient must clock in and out using LTSS App

PT CAREPLAN
PT frequency WK2: 1 (09/13/26-09/19/26),WK3: 1 (09/20/26-09/26/26),WK5: 1 (10/04/26-10/10/26),WK6: 1 (10/11/26-10/17/26)

09/15/2026 Problems : GG0170G1 - Car Transfer
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130F1 - Upper Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170E1 - Chair to Bed to Chair
GG0170D1 - Sit to Stand
GG0170P1 - Picking Up Object
GG0170O1 - 12 Steps
GG0170N1 - 4 Steps
GG0170M1 - 1 - Step (curb)
GG0170K1 - Walk 150 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170I1 - Walk 10 Feet
GG0170F1 - Toilet Transfer

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: seated knee ext, hip flex, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex, hip abd at least 1x10 with UE support as needed. Upgrade as tolerated, equipment training, work simplification/energy conservation, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching 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

PT NARRATIVE
PT Eval completed. Pt is a 81 y.o. female with PMH significant for asthma, history of falls, HTN, hypothyroidism, Vitamin D deficiency who was recently hospitalized due to CVA with resulting aphasia and R side weakness as well as remaining G tube in abdomen that will be removed soon. Prior to hospitalization, pt had been ambulating independently with SPC indoors and RW outdoors. At this time, pt presents with decreased strength with 3/5 MMT in BLE and requires CGA for ambulation with RW. Pt is primarily limited due to decreased endurance and would benefit from skilled PT services to increase strength and safety in mobility in order to return to PLOF.

PT GOALS
PATIENT-STATED GOAL: To be able to walk without help

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

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

Toilet Transfer - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 04. Supervision or touching 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

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/11/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.
F2F date: 08/14/2026

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.

Certifying Physician or Allowed Practitioner Name and Address **Jessica Friedman**
1111 North Charles St
Baltimore, MD 21201
NPI 1851745517

Phone Number 4108372050

Fax Number 18666290091

Physician's Signature and Date Signed

X

Jessica Friedman, MD
08/14/2026: Date of physician last face-to-face