Home Health Certification and Plan of Care

Order ID: 1150/15191

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
81160764	12/24/2025	From: 12/24/2025 To: 02/21/2026	20716	217058

6. Patient's Name and Address
Stephaney Hibbert
1000 Arion Park Road Apt 90,
BALTIMORE, MD 21229-
443-525-4531

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 05/08/1960 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z48.815	Encntr for surgical aftcr following surgery on the dgstv sys	12/24/25

13. ICD	Other Pertinent Diagnoses	Date
M35.1	Other overlap syndromes	12/24/25
I10.	Essential (primary) hypertension	12/24/25
M32.9	Systemic lupus erythematosus unspecified	12/24/25
K44.9	Diaphragmatic hernia without obstruction or gangrene	12/24/25
M81.0	Age-related osteoporosis w/o current pathological fracture	12/24/25
I73.00	Raynaud's syndrome without gangrene	12/24/25
K59.09	Other constipation	12/24/25
A04.72	Enterocolitis d/t Clostridium difficile not spcf as recur (A04.72)	12/24/25
D63.8	Anemia in other chronic diseases classified elsewhere	12/24/25
K21.9	Gastro-esophageal reflux disease without esophagitis	12/24/25
Z43.3	Encounter for attention to colostomy	12/24/25
Z90.49	Acquired absence of other specified parts of digestive tract	12/24/25

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

Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 mg , Take 1 tablet by mouth every 6 hours oxyCODONE 5 mg immediate release tablet
Take 1 tablet by mouth every 6 hours as needed for Breakthrough Pain.
Polyethylene Glycol 3350 - Polyethylene Glycol 3350 17 g packet Take 1 packet by mouth once a day 17 g packet
Take 1 packet by mouth daily. Stir and dissolve 1 packet in any 4-8 ounces of noncarbonated beverage.
Senna - Senna 8.6 MG Tabs Take 2 tablets by mouth at bedtime Take 2 tablets by mouth nightly.
Amlodipine - Amlodipine Besylate 10 MG tablet Take 10 mg by mouth once a day 10 MG tablet
Take 10 mg by mouth daily
Losartan Potassium - Losartan Potassium 25 MG tablet Take 25 mg by mouth once a day 25 MG tablet
Take 25 mg by mouth daily
Pantoprazole - Pantoprazole Sodium 40 mg tablet, Take 40 mg by mouth twice a day pantoprazole 40 mg tablet delayed release
Take 40 mg by mouth 2 times daily.
Ondansetron - Ondansetron 4 mg 4 mg, Take 1 tablet by mouth every 8 hours 4 mg disintegrating tablet
Take 1 tablet by mouth every 8 hours as needed for Nausea.
Hydroxychloroquine Sulfate - Hydroxychloroquine Sulfate 200 MG tablet by mouth once a day 200 MG tablet daily
Extra Strength Tylenol - Acetaminophen 2 tbs by mouth every 6 hours Take 2 tabs 1000mg every 6 hours prn for pain
Centrum Silver - Ascorbic Acid: Biotin: Cyanocobalamin: Ergocalciferol: Folic Acid: Niacinamide: Pantothenic Acid: Phytonadione: Pyridoxine: Ribo 1 tab by mouth once a day Take obevitamin daily for supplement
Gas-X - Senna 1 tab by mouth twice a day For gas

14. DME and Supplies:
ostomy supplies

15. Safety Measures:
smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with assistance, , , , activity supervision

16. Nutrition:
low fiber

17. Allergies:
Lisinopril

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
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: 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: After undergoing Colostomy Placement, 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 65-year-old individual with a history of bowel obstruction who underwent prior abdominal surgery approximately seven years ago, complicated by postoperative adhesions that subsequently resulted in recurrent bowel obstruction. Past medical history is significant for gastroesophageal reflux disease (GERD), mixed connective tissue disease/lupus, Raynaud's syndrome, osteoporosis, hypertension, and diaphragmatic hernia with reflux. The patient is currently postoperative day five following colostomy placement for bowel obstruction. She resides alone in a second-floor apartment with approximately 13-14 steps to enter, equipped with a handrail. Although her granddaughter is currently providing temporary assistance, she is expected to leave shortly, and the patient will resume living alone. Functionally, the patient ambulates indoors approximately 30 feet without an assistive device under supervision. She is able to negotiate 14 steps using a handrail with a step-to pattern and supervision. Transfers to the toilet, bed, and sofa are completed with supervision, and bed mobility requires supervision with frequent verbal cues to maintain abdominal precautions. Outdoor mobility and car transfers were not assessed at the time of evaluation. The patient is considered homebound due to the significant effort required to leave the home, as evidenced by a Tinetti score of 16/28, indicating an increased fall risk. She tolerated therapeutic exercise including 10 repetitions each of supine hip flexion, bridging, hook-lying trunk rotation, straight leg raises, and hip abduction. Continued home-based physical therapy is recommended to address decreased strength, balance, and functional mobility with the goal of improving safety and progressing toward prior levels of independence. From an occupational therapy perspective, the patient is currently independent with basic grooming, dressing, and sponge bathing. Showering is restricted at this time due to abdominal staples. Occupational therapy recommends skilled intervention one time per week for three weeks to address activities of daily living training, therapeutic exercise, development of a home

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 12/24/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Christelle Nong Libend
1701 Twin Springs Road
Halethorpe, MD 21227
PHONE: FAX: NPI: 1780096446

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 : 12/19/2025

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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exercise program, functional mobility, and safety training to support independence in the home environment. The patient is new to colostomy care and requires extensive education regarding colostomy bag management, including hands-on instruction with teach-back to ensure understanding and safe performance. She will require ongoing education, reinforcement, and provision of appropriate colostomy supplies to safely manage her ostomy at home. The plan of care includes continued skilled nursing for postoperative and ostomy management education, physical therapy to improve strength, balance, and mobility, and occupational therapy to maximize functional independence and safety while adhering to abdominal precautions.
 Date of Order 12/24/2025 Orders Physician Face-to-Face Date: 12/19/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat HHA due to Colostomy Placement 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 Nong Libend, Christelle

SN Careplans

SN WK1: 1 (12/24/25-12/27/25) ,WK2: 1 (12/28/25-01/03/26) ,WK3: 2 (01/04/26-01/10/26) ,WK4: 2 (01/11/26-01/17/26) ,WK5: 1 (01/18/26-01/24/26) ,WK6: 1 (01/25/26-01/31/26) ,WK7: 1 (02/01/26-02/07/26) ,WK8: 1 (02/08/26-02/14/26)

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, 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; 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, limited strength, limited endurance, muscle weakness, Pain Effect on Sleep, Pain Interference with ADLs, M1630 - GI Ostomy, #1 - GI Ostomy - Other - Lower abdominal - New ostomy with beefy red stoma. Surrounding skin intact, #2 - Observable Surgical Wound - Other - Abdominal midline - Staples in place. Wound bed unable Tobe visualized.

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply collection/fistula pouch, ostomy care & irrigation: 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., teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

SN Goals

PATIENT-STATED GOAL: Patient states she wants to be able to feel comfortable leaving the house again

GOALS
patient/caregiver recalls
* diet
* weight-bearing exercises to promote bone healing and strengthening
* fluids to prevent constipation
* home safety
* pain control
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* 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 relaxatio

patient/caregiver recalls
* ostomy management including how to clean stoma
* change ostomy pouch
* 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	12/24/2025

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TEACH PATIENT/CAREGIVER: * lifestyle modification to manage blood condition including dietary changes bleeding precautions, 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 relaxatio, * ostomy management including how to clean stoma change ostomy pouch, related medication(s) purpose, schedule, * diet weight-bearing exercises to promote bone healing and strengthening fluids to prevent constipation home safety pain control, 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 WK2: 2 (12/28/25-01/03/26) ,WK3: 1 (01/04/26-01/10/26) ,WK4: 1 (01/11/26-01/17/26) ,WK5: 1 (01/18/26-01/24/26) ,WK6: 1 (01/25/26-01/31/26) ,WK7: 1 (02/01/26-02/07/26) ,WK8: 1 (02/08/26-02/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, GG0170F1 - Toilet Transfer - 05. Setup or clean-up assistance, GG0170D1 - Sit to Stand - 02. Substantial/maximal assistance, GG0170E1 - Chair to Bed to Chair - 02. Substantial/maximal assistance, GG0170G1 - Car Transfer - 02. Substantial/maximal assistance, GG0170I1 - Walk 10 Feet - 05. Setup or clean-up assistance, GG0170J1 - Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, GG0170K1 - Walk 150 Feet - 05. Setup or clean-up assistance, GG0170L1 - Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, GG0170M1 - 1 - Step (curb) - 05. Setup or clean-up assistance, GG0170N1 - 4 Steps - 05. Setup or clean-up assistance, GG0170O1 - 12 Steps - 05. Setup or clean-up assistance, GG0170P1 - Picking Up Object - 05. Setup or clean-up assistance

PROCEDURES: Home exercise program : Supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps , Bed mobility training , Dynamic and static standing balance training, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * 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 relaxatio, 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, Chair to Bed to Chair - 02. Substantial/maximal assistance, Sit to Stand - 06. Independent

PT Goals

PATIENT-STATED GOAL: Be able to get around the community by myself

GOALS
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

Car Transfer - 05. Setup or clean-up assistance

Picking Up Object - 06. Independent

Chair to Bed to Chair - 02. Substantial/maximal assistance

Sit to Stand - 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 relaxatio

4 Steps - 06. Independent

12 Steps - 06. Independent

OT Careplans

OT WK2: 1 (12/28/25-01/03/26) ,WK3: 1 (01/04/26-01/10/26) ,WK4: 1 (01/11/26-01/17/26) ,WK5: 1 (01/18/26-01/24/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene - 05. Setup or clean-up assistance, GG0130F1 - Upper Body Dressing - 05. Setup or clean-up assistance, GG0130G1 - Lower Body Dressing - 05. Setup or clean-up assistance, GG0130H1 - Don/Doff Footwear - 05. Setup or clean-up assistance, GG0130E1 - Shower/Bathe Self - 04. Supervision or touching assistance, GG0130C1 - Toileting Hygiene - 05. Setup or clean-up assistance, GG0130A1 - Eating - 05. Setup or clean-up assistance

PROCEDURES: cough/deep breathing exercises, therapeutic exercises, equipment training, work simplification/energy conservation, transfers training, assist with meal preparation

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 medicatio, 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

OT Goals

PATIENT-STATED GOAL: To get back to my self

GOALS
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 medicatio

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

12/24/2025