Home Health Certification and Plan of Care

Order ID: 1150/19197

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
54267178	05/30/2026	From: 05/30/2026 To: 07/28/2026	26268	217058

6. Patient's Name and Address

Arnetta Howard
904 Edgewood Rd Apt 315,
Edgewood, MD 21040
443-752-6629

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 05/13/1935 | **9.Sex** Female

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

Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25 MCG (1000 UT) / 1 Tablet by mouth daily
LOVENOX 80 mg/0.8 mL / Inject 0.75 mL subcutaneous every 12 hours for 7 days Follow up within one week with Anticoagulation Service or primary doctor
Urea (CARMOL 20) 20 % Top Cream / Apply to affected area(s) topical twice a day

11. ICD	Principal Diagnosis	Date
I82.412	Acute embolism and thrombosis of left femoral vein	05/30/26

13. ICD	Other Pertinent Diagnoses	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	05/30/26
N18.30	Chronic kidney disease stage 3 unspecified	05/30/26
E78.00	Pure hypercholesterolemia unspecified	05/30/26
M67.40	Ganglion unspecified site	05/30/26
R73.03	Prediabetes	05/30/26
E66.9	Obesity unspecified	05/30/26
Z68.30	Body mass index [BMI] 30.0-30.9 adult	05/30/26
Z79.01	Long term (current) use of anticoagulants	05/30/26

14. DME and Supplies:

wheelchair, rolling walker, hand held shower, bath bench, walker, grab bars, 4 wheeled walker

15. Safety Measures:

wheelchair precautions, standard precautions, hand rails, fall precautions, bleeding precautions, ambulates with device, walker precautions, smoke detectors , medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, supervision at all times, sharps precautions, medical alert/lifeline, cardiac precautions, bathroom safety, anticoagulant precautions, activity supervision

16. Nutrition:

high protein

17. Allergies:

penicillin

18.A. Functional Limitations

Endurance, Bowel/Bladder Incontinence, Ambulation, Hearing

18.B. Activities Permitted

Wheelchair, Exercises Prescribed, Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 3. Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time., 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, HISTORY OF DEPRESSION: No

20. Prognosis: good

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
family/caregiver will be responsible for managing treatment
family/caregiver will be responsible for managing treatment
family/caregiver will be responsible for managing treatment
family/caregiver will be responsible for managing treatment
add discharge plan

Homebound status: Due to diagnosis of Acute embolism and thrombosis of left femoral vein, 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: Patient is a 91-year-old female referred to home health services following hospitalization for left lower extremity swelling and subsequent diagnosis of a left lower extremity deep vein thrombosis (DVT), confirmed by ultrasound. Her past medical history is significant for hypertension, chronic kidney disease (CKD), prediabetes, hypercholesterolemia, and obesity. The patient resides in a senior apartment with elevator access and lives with her daughter, Tina, who serves as her full-time caregiver and provides substantial assistance with daily care needs. A MOLST is on file, and the patient remains Full Code. Following diagnosis of the DVT, the patient was initiated on enoxaparin therapy administered subcutaneously twice daily for one week. Education was provided regarding anticoagulation management, including the ability to gradually adjust administration times to establish a more convenient dosing schedule. The patient and caregiver were informed that the pharmacy will coordinate with the provider regarding transition to oral anticoagulation therapy and that uninterrupted anticoagulation coverage is essential during the transition process. They were instructed that the oral anticoagulant should be initiated 12 hours after the final enoxaparin dose. The patient and caregiver verbalized understanding of the treatment plan, medication regimen, and transition instructions. All prescribed medications are available in the home. On nursing assessment, the patient was noted to have no wounds, pressure injuries, or evidence of skin breakdown. Education was provided regarding the importance of maintaining adequate nutrition with a high-protein diet to support overall health and tissue integrity. The patient and caregiver were also instructed to apply barrier cream multiple times daily to protect the skin and prevent breakdown associated with brief use. Ongoing monitoring for skin integrity was encouraged. Prior to hospitalization, the patient required assistance with activities of daily living (ADLs) and bed mobility, provided primarily by her daughter, and ambulated with a rolling walker. Physical therapy evaluation revealed significant functional decline characterized by impaired balance, lower extremity weakness, reduced endurance, gait abnormalities, and transfer difficulties. The patient demonstrated a Tinetti Balance and Gait Assessment score of 8/28, indicating a high risk for falls. Gait assessment revealed ambulation with a flexed trunk posture, decreased heel strike, and poor positioning within the rolling walker, including standing too far from the device. Recommendations were made to remove area rugs and address environmental hazards to reduce fall risk. The patient presents with decreased strength, impaired balance, and limited activity tolerance that negatively impact safe mobility and functional independence. Given her supportive caregiving environment and motivation to improve, she demonstrates good rehabilitation potential and is expected to benefit from skilled physical therapy interventions focused on strengthening, balance training, gait mechanics, transfer training, endurance enhancement, and fall prevention. Occupational therapy evaluation further identified deficits in standing balance, standing tolerance, bilateral upper extremity strength, and overall activity tolerance. Prior to hospitalization, the patient required assistance with self-care tasks from her daughter but was independent with functional transfers and household ambulation. At the time of evaluation, these impairments were contributing to decreased performance in self-care activities, functional transfers, and mobility-related tasks. Skilled occupational therapy services are indicated to address deficits in strength, endurance, balance, and functional performance with the goal of maximizing safety, independence, and return to her prior level of function within the home environment. The patient continues to require skilled nursing, physical therapy, and occupational therapy services for anticoagulation management, disease process education, medication management, fall prevention, strengthening, mobility training, and assistance in achieving the highest possible level of functional independence while remaining safely at home with caregiver support.
 Date of Order 05/30/2026 Orders Physician Face-to-Face Date: 05/23/2026 Clinical Condition Requiring Home Care per

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/30/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Charles Olaleye
1221 Mercantile Lane
Largo, MD 20774
PHONE: 8007777904 FAX: NPI: 1407261704

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 : 05/23/2026

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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Certifying Physician: SN-disease management, PT-eval & treat, OT-eval & treat, HHA due to Acute embolism and thrombosis of left femoral vein 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 Olaleye, Charles

SN Careplans

SN WK1: 1 (05/30/26-05/30/26) ,WK2: 1 (05/31/26-06/06/26) ,WK3: 2 (06/07/26-06/13/26) ,WK4: 1 (06/14/26-06/20/26) ,WK5: 1 (06/21/26-06/27/26) ,WK6: 1 (06/28/26-07/04/26)

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, 4. Multiple emergency department visits (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/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, M1700 - Cognition, M1720 - Anxiety, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1033 - Exhaustion, M1400 - Dyspnea, nausea/vomiting, M1620 - Bowel Incontinence, frequent urination, M1610 - Urinary Incontinence, muscle weakness, limited strength, limited endurance, B0200 - Hearing Deficit, difficulty sleeping, balance deficit, daytime fatigue, loss of appetite

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange home modifications for hearing impaired, i.e. alarms

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, * 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, * 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, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, related

SN Goals

PATIENT-STATED GOAL: Caregiver states she wants her mom to regain her strength back so she can walk 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

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
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* 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

caregiver administers and/or packages medications appropriately

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 keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/30/2026

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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: 1 (05/31/26-06/06/26) ,WK3: 2 (06/07/26-06/13/26) ,WK4: 1 (06/14/26-06/20/26) ,WK5: 1 (06/21/26-06/27/26) ,WK6: 1 (06/28/26-07/04/26) ,WK7: 1 (07/05/26-07/11/26) ,WK8: 1 (07/12/26-07/18/26) ,WK9: 1 (07/19/26-07/25/26) ,WK10: 1 (07/26/26-07/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Medication management : Review medication with patient and caregiver, home exercise program: Laq, hip abduction, hamstring curls, hip flexion, toe raises, dynamic standing balance exercises: Focus on improving weight shifting Reaching minimally outside base of support, increased stability standing over base of support., gait training on uneven surfaces, gait training/stair training, transfers 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 - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: To get stronger and improve my balance and walk better with the walker

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

OT Careplans

OT WK2: 1 (05/31/26-06/06/26) ,WK4: 1 (06/14/26-06/20/26) ,WK6: 1 (06/28/26-07/04/26) ,WK8: 1 (07/12/26-07/18/26) ,WK10: 1 (07/26/26-07/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing

PROCEDURES: Medication Review : Medication reviewed with patient and caregiver with all medications in the home, home exercise program: Bilateral UE strengthening of deltoid, biceps, triceps and pectoral muscles, therapeutic exercises: Skilled OT, equipment training, work simplification/energy conservation, transfers training: Skilled OT, assist with bathing: Skilled OT, assist with toilet transferring: 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 05. Setup or clean-up assistance, Upper Body Dressing - 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

Oral Hygiene - 06. Independent

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 05. Setup or clean-up assistance

Upper Body Dressing - 06. Independent

HHA Careplans

HHA WK3: 2 (06/07/26-06/13/26) ,WK4: 2 (06/14/26-06/20/26) ,WK5: 2 (06/21/26-06/27/26) ,WK6: 2 (06/28/26-07/04/26)

PROCEDURES: assist with bathing: Mod A, assist with toilet transferring: Min A, assist with toileting hygiene: Min A, assist with mobility, assist with feeding/eating, assist with fall prevention, assist with grooming: Setup, assist with lower body dressing: Min A, assist with upper body dressing: Mod A

HHA Goals

PATIENT-STATED GOAL: add patient-stated goal

GOALS

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/30/2026