Home Health Certification and Plan of Care

Order ID: 1150/19872

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
51357033	06/17/2026	From: 06/17/2026 To: 08/15/2026	27160	217058

6. Patient's Name and Address
Inga Riley
5113 Kramme Avenue,
BROOKLYN, MD 21225-
443-813-3223

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 02/16/1960 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I82.412	Acute embolism and thrombosis of left femoral vein	06/17/26

13. ICD	Other Pertinent Diagnoses	Date
I26.92	Saddle embolus of pulmonary artery w/o acute cor pulmonale	06/17/26
E11.43	Type 2 diabetes w diabetic autonomic (poly)neuropathy	06/17/26
K31.84	Gastroparesis	06/17/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	06/17/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/17/26
N18.9	Chronic kidney disease u	06/17/26
E78.5	Hyperlipidemia unspecified	06/17/26
F32.A	Depression unspecified	06/17/26
E11.65	Type 2 diabetes mellitus with hyperglycemia	06/17/26
I34.0	Nonrheumatic mitral (valve) insufficiency	06/17/26
Z79.01	Long term (current) use of anticoagulants	06/17/26
Z79.4	Long term (current) use of insulin	06/17/26
Z79.891	Long term (current) use of opiate analgesic	06/17/26

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

ROXICODONE 5 mg by mouth every 6 hours PRN As needed for.pain
Reglan - Metoclopramide Hydrochloride 10 mg by mouth as necessary every 6 hours for nausea and vomiting
prucalopride (MOTEGRITY) 2 mg by mouth 1 time daily
PROTONIX eq 40 mg base by mouth 1 time daily 30-60 min before meals
Pepcid - Famotidine 40 mg by mouth once a day
Lipitor - Atorvastatin Calcium 40 mg by mouth once a day Cholesterol
Cozaar - Losartan Potassium 100 mg by mouth once a day
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5MG by mouth four times a day
Dabigatran Etexilate - Dabigatran Etexilate 150MG by mouth every 12 hours
Lovenox - Enoxaparin Sodium 70 mg subcutaneous twice a day
Insulin Glargine-yfgn (SEMGLEE) 30 Units subcutaneous once a day
Insulin Aspart-xjhz 15 Units subcutaneous three times a day before meals
Patient is taking according to SS
Mycostatin - Nystatin 100000 UNIT/GM Powder / 1 Application topical twice a day
Nizoral - Ketoconazole 2 % cream / 1 Application topical twice a day Under breast

14. DME and Supplies:
bath bench, diabetic supplies

15. Safety Measures:
anticoagulant precautions, diabetic precautions, fall precautions, medication safety

16. Nutrition:
cardiac diet, diabetic

17. Allergies:
aspirin

18.A. Functional Limitations
None of the above

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: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

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
patient will be responsible for managing treatment

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: The patient is a 66-year-old African American female admitted to home health services following multiple recent hospitalizations related to acute pulmonary embolism (PE), left lower extremity deep vein thrombosis (DVT), abdominal pain, and chest pain. Her past medical history is significant for type 2 diabetes mellitus, hypertension, gastroparesis, chronic kidney disease, acute kidney injury, microalbuminuria secondary to diabetes, obesity, and depression. Upon assessment, the patient was alert and oriented 4 and seated comfortably in her living room. She reported shortness of breath with exertion, mild chest pain, and persistent left lower extremity pain involving the calf and posterior knee, all rated at 4/10. She also reported intermittent severe abdominal cramping rated at 12/10. Vital signs were obtained and were as follows: temperature 97.3F, pulse 78 bpm, oxygen saturation 98% on room air, and blood pressure 152/88 mmHg in the right arm while seated. Physical assessment revealed clear lung sounds bilaterally, audible bowel sounds, trace edema of the left lower extremity, palpable peripheral pulses, and warm, intact skin. The patient reported having a bowel movement earlier in the day and denied dysuria or urinary discomfort. Blood glucose monitoring via Dexcom revealed a reading of 265 mg/dL. A comprehensive medication review was completed. The patient expressed confusion regarding her medication regimen and reported relying on her son to provide medications from her bedroom. During reconciliation, two bottles of losartan with different dosages were identified. Based on the most recent hospital discharge instructions, the patient should be taking losartan 100 mg daily; therefore, the 50 mg bottle was removed and set aside by her son to prevent medication errors. The patient also reported not administering her full prescribed dose of rapid-acting insulin due to decreased oral intake. Education was provided regarding medication adherence, insulin administration, and the importance of discussing dosage adjustments with her physician to maintain therapeutic blood glucose control. The patient reported she will begin Pradaxa on Thursday and discontinue Lovenox as instructed, and she also requires a refill of hydralazine 50 mg three times daily, which is expected to be initiated once obtained. Physical therapy evaluation was completed following hospitalization for acute DVT and PE. The patient resides with her fianc, who is available to provide assistance as needed. She lives in a two-level home with four steps to enter but remains on the first floor where all essential living areas are located. Prior to hospitalization, she did not require an assistive device and reported no falls within the past year. Current assessment revealed bilateral lower extremity pain, decreased strength, decreased functional mobility, difficulty negotiating stairs, unsteady gait, impaired balance, difficulty with transfers, and increased risk for falls. These deficits place the patient at risk for further functional decline and loss of independence without skilled intervention. The patient will benefit from skilled physical therapy services to improve lower extremity strength, balance, transfer ability, gait safety, stair negotiation, endurance, and overall functional mobility. Occupational therapy evaluation further identified limitations associated with her recent medical decline and comorbid conditions, including visual impairment related to cataracts, tingling in the hands and feet, reduced activity tolerance, and difficulty performing prolonged tasks and stair negotiation. Although the patient remains largely independent with basic activities of daily living and household mobility, she requires supervision, frequent rest breaks, and activity modification due to fatigue and decreased endurance. Skilled occupational therapy services are warranted to improve functional independence with activities of daily living and instrumental activities of daily living, reduce fall risk, prevent deconditioning, and maximize safety within the home environment. The patient demonstrated understanding of all education provided and remains appropriate for ongoing skilled nursing, physical therapy, and occupational therapy services for disease management, medication education, cardiopulmonary monitoring, diabetic management, strengthening, mobility training, safety instruction, and prevention of further functional

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 06/17/2026

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 : 06/16/2026

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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decline.
 Date of Order 06/17/2026 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 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 OT Eval Notes: PT Eval Notes:
 Physician Nong Libend, Christelle

SN Careplans

SN WK1: 1 (06/17/26-06/20/26) ,WK2: 2 (06/21/26-06/27/26) ,WK3: 1 (06/28/26-07/04/26) ,WK4: 1 (07/05/26-07/11/26) ,WK5: 1 (07/12/26-07/18/26)

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, blood sugar < 60 > 300

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:Refused

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M2102c - Med Admin, weak pulses in feet, swelling in legs/around eyes, chest pain, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, limited strength, balance deficit, Pain Effect on Sleep, Pain Interference with ADLs, B1000 - Vision Deficit

PROCEDURES: cough/deep breathing exercises, apply compression bandage, glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange resources for vision-impaired

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

SN Goals

PATIENT-STATED GOAL: "I would like to get my meds right."

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
* 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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

caregiver administers and/or packages medications appropriately

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

06/17/2026

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PT WK1: 1 (06/17/26-06/20/26) ,WK2: 1 (06/21/26-06/27/26) ,WK3: 1 (06/28/26-07/04/26) ,WK4: 1 (07/05/26-07/11/26) ,WK5: 1 (07/12/26-07/18/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, 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: home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention: Teach on Falls prevention -use recomended AD at all times and/or direct assistance by CG as needed -make sure clothing does not drag on floor to create trip hazard -proper footwear, no scuffs - Strength program has been initiated for LEs, continue 1-2x/day -carry phone at all times in case of emergency -Consider medic alert button -Fall recover technique discussed -Keep stairs free of obstacles -Maintain functional pathways throughout the home and at all exits -use night lights -Advised against holding onto towel bars or soap dishes, consider grab bars, check grab bars before use -remove scatter rugs, if one must remain use double sided rug tape -Add non skid mat in the shower -keep the floor dry in the bathroom, if using a shower seat dry self completely before stepping out.

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 relaxation skills and diversional activities, related medication(s) purpose, schedule, 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

PATIENT-STATED GOAL: I just want to get stronger in y legs and arms

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

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

OT Careplans

OT WK1: 1 (06/17/26-06/20/26) ,WK2: 1 (06/21/26-06/27/26) ,WK3: 1 (06/28/26-07/04/26) ,WK4: 1 (07/05/26-07/11/26) ,WK5: 1 (07/12/26-07/18/26) ,WK6: 1 (07/19/26-07/25/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, 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: activity tolerance : To improve activity endurance with less or no breaks, Medication review : med list updates, Improve UE strength : Improve strength in shoulder, elbow and wrist to 4, cough/deep breathing exercises, incentive spirometer, home exercise program: Strengthening exe for shoulder, elbow and wrist, equipment training, work simplification/energy conservation

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, 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: Be able to do daily routine

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 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 relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

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
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/17/2026