Home Health Certification and Plan of Care

Order ID: 1150/21346

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: 08/16/2026 To: 10/14/2026	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

prucalopride (MOTEGRITY) 2 mg by mouth 1 time daily
PROTONIX eq 40 mg base by mouth 1 time daily 30-60 min before meals
Cozaar - Losartan Potassium 100 mg by mouth once a day
Dabigatran Etexilate - Dabigatran Etexilate 150MG by mouth every 12 hours
Lipitor - Atorvastatin Calcium 40 mg by mouth once a day Cholesterol, dose changed to half a tablet daily, on July 13
Lyrica - Pregabalin 50 mg by mouth twice a day
Insulin Glargine-yfgn (SEMGLEE) 25 Units subcutaneous once a day
Insulin Aspart-xjhz 8 Units subcutaneous three times a day 8 units before meals, if needed 4 units after meal
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:
walker

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

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
aspirin

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
No Restrictions

19. Mental & Pyschosocial Status: COGNITION: 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer, ANXIETY: , SOCIAL ISOLATION: 1 Requires assistance, BEHAVIORAL ISSUES: 2 independent, HISTORY OF DEPRESSION:

20. Prognosis: good

22. A Rehabilitation Potential:
SELF-CARE: Good, MOBILITY: -

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 decline.
 Date of Order 08/12/2026 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
 4 - Recertification Notes: The patient is recertified due to clots found on CT scan after the patient went to the ER, with the

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 08/12/2026

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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clots not yet determined to be old or new. The patient also has R ankle and toe pain during today's visit, requiring continued skilled nursing assessment and medication review.
 Physician Nong Libend, Christelle

SN Careplans

SN Goals

OT Careplans

OT WK1: 1 (08/16/26-08/22/26) ,WK2: 1 (08/23/26-08/29/26)

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:

HOSPITALIZATION RISKS: 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; 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: dependent edema, M1033 - Exhaustion, abdominal pain, limited endurance, difficulty sleeping, extremity burn/tingle/numb, lethargy, balance deficit, loss of appetite, discolored patches of skin

PROCEDURES: cough/deep breathing exercises, glucose testing via monitor, home exercise program: exe to improve UE and activity toelrance level, equipment training, work simplification/energy conservation, monitor dialysis schedule

TEACH PATIENT/CAREGIVER: * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, 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: to be independent in ADLs

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* 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 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/12/2026