# Home Health Certification and Plan of Care

**Order ID: 1150/15878**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 87161336 | 01/29/2026 | From: 01/29/2026 To: 03/29/2026 | 21316 | 217058 |

**6. Patient's Name and Address**

Catherine Epling
719 Route 3 North,
GAMBRILLS, MD 21054-
240-423-6929

**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** 08/28/1940 | **9.Sex** Female

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| I11.0 | Hypertensive heart disease with heart failure | 01/29/26 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| I50.32 | Chronic diastolic (congestive) heart failure | 01/29/26 |
| S22.42XD | Multiple fx of ribs left side subs for fx w routn heal | 01/29/26 |
| I48.11 | Longstanding persistent atrial fibrillation | 01/29/26 |
| I49.5 | Sick sinus syndrome | 01/29/26 |
| K21.9 | Gastro-esophageal reflux disease without esophagitis | 01/29/26 |
| Z79.01 | Long term (current) use of anticoagulants | 01/29/26 |
| Z79.891 | Long term (current) use of opiate analgesic | 01/29/26 |
| Z95.0 | Presence of cardiac pacemaker | 01/29/26 |
| Z91.81 | History of falling | 01/29/26 |

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

Biscodyl - Bisacodyl: Polyethylene Glycol 3350: Potassium Chloride: Sodium Bicarbonate: Sodium Chloride 17gram by mouth once a day for bowel regime prn use

Amiodarone - Amiodarone Hydrochloride 100MG; 1 tab by mouth once a day for A.Fib

Metoprolol Tartrate - Metoprolol Tartrate 25 mg 25mg; 1/2 tab by mouth four times a day HTN

Eliquis - Apixaban 005MG; 1 TAB by mouth twice a day for afib

Atorvastatin - Atorvastatin Calcium 0020MG; TAB by mouth at bedtime CHOLESTEROL

**14. DME and Supplies:**

grab bars, rolling walker, walker, commode

**15. Safety Measures:**

hand rails, , , ambulates with device, walker precautions, , ambulates with assistance, transfer with assist, supervision at all times, ,

**16. Nutrition:**

cardiac diet

**17. Allergies:**

no known allergies

**18.A. Functional Limitations**

Endurance, Dyspnea With Minimal Exertion, Ambulation

**18.B. Activities Permitted**

Up As Tolerated, Walker, Exercises Prescribed

**19. Mental & Pyschosocial Status:** COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., 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:** fair

**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
patient will be responsible for managing treatment

**Homebound status:**

Due to diagnosis of Hypertensive Heart Disease With Heart Failure, 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 an 85-year-old female recently discharged home on 01/23/26 following hospitalization and inpatient rehabilitation after a fall down stairs on 12/15/25-12/16/25, during which she experienced lightheadedness with head strike but no loss of consciousness. Imaging revealed a left gluteal hematoma, multiple left-sided rib fractures, and a wedge compression fracture of the first lumbar vertebra with subsequent nonunion. Her past medical history is significant for diastolic heart failure, longstanding persistent atrial fibrillation with rapid ventricular response status post cardioversion x2, non-sustained supraventricular tachycardia, sick sinus syndrome status post pacemaker placement, bradycardia, essential hypertension, hypovolemia, GERD without esophagitis, rheumatoid arthritis, generalized muscle weakness, chronic low back pain, history of falls, nontraumatic soft tissue hematoma, and abnormal cardiovascular function studies. She was hospitalized for four days at Johns Hopkins Bayview and subsequently transferred to Autumn Lake Rehabilitation before returning home with family assistance. The patient resides in a multilevel home with her son and grandson, who serve as primary caregivers and assist with ADLs and IADLs as needed. The home has approximately five steps to enter, with a full flight of stairs leading to the bedroom and bathroom on the second floor. At present, the patient is sleeping on a sofa on the main level and utilizing a bedside commode, which has been adjusted to appropriate height. She expressed a strong desire to regain the ability to safely access her second-floor bedroom and bathroom. A home safety assessment was completed, and physical therapy and skilled nursing plans of care were discussed and developed with the patient and caregivers, who verbalized understanding and agreement. On skilled nursing assessment, the patient was alert and oriented to person and place (x2) and reoriented easily. She denied pain at the time of visit, with pain reported as well controlled on current medications. She endorsed decreased appetite and intermittent nausea since rehabilitation, with last bowel movement reported as the day prior to the visit. Skilled nursing provided education on small, frequent meals to promote adequate nutritional intake. The patient denied shortness of breath at rest but reported intermittent shortness of breath with minimal exertion. No peripheral edema was noted. She continues to experience generalized weakness and ambulates with a rolling walker for safety. Medication review was completed, including medication names, dosages, frequencies, and pertinent side effects. The patient reported that she had taken her last dose of Eliquis and was awaiting discussion with her primary care provider during a scheduled virtual/phone visit on the day of assessment regarding a possible change in anticoagulation therapy, noting a prior history of Pradaxa use. She was instructed to reconcile all discharge medications with her provider. Skilled nursing plans to complete medication reconciliation and update the medication profile at the next visit as indicated. A physical therapy evaluation was completed with consents obtained. The patient demonstrates decreased endurance, decreased bilateral lower extremity strength, impaired balance, unsteady gait, difficulty with transfers, impaired stair negotiation, decreased functional mobility, decreased safety awareness, and a high risk for falls. To safely leave the home, she requires assistance from another person and the use of an assistive device. Without skilled physical therapy intervention, the patient is at increased risk for further falls, functional decline, and loss of independence. During the physical therapy visit, the patient was instructed in safe transfer techniques using a rolling walker, including proper hand and foot placement, forward weight shift, and reaching back to the chair prior to sitting. She required minimal assistance to standby assistance for transfers. She was instructed in and performed a supine therapeutic exercise program consisting of ankle pumps, quad sets, and gluteal sets (1 x 20 repetitions) and heel slides (1 x 10 repetitions). A written home exercise program was left in the home with instructions to complete exercises twice daily. Gait training was performed on level surfaces using a rolling walker, with standby assistance required for safety. Verbal cues were provided for proper positioning within the walker, increased step height and length, and overall safety. Tinetti and Timed Up and Go (TUG) assessments were completed, and the patient was strongly advised to ambulate with the rolling walker at all times. Education was provided regarding the importance and benefits of daily ambulation to improve circulation and prevent complications related to inactivity. The patient was instructed to initiate a walking program consisting of short walks every 1-2 hours within the home, beginning with longer walks of 3-5 minutes and progressing gradually as tolerated. She was also instructed to apply heat to the low back for

**23. Signature and Date of Verbal SOC Where Applicable:**

Electronically Signed by Messick, Charles RN on 01/29/2026

**25. Date HHA Received Signed POT**

**24. Physician's Name and Address**

Anise Henry
888 Annapolis Rd
Annapolis, MD 21401
PHONE: FAX: NPI: 1376768184

**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 : 01/20/2026

**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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| Catherine Epling<br>719 Route 3 North,<br>GAMBRILLS, MD 21054-<br>240-423-6929 | HomeCentris Healthcare LLC<br>10 Crossroads Drive, Suite 102<br>Owings Mills, MD 21117-8284<br>410-321-8448<br>1487113239 |

20 minutes with an appropriate barrier, performing skin checks every five minutes. Pain management education included taking pain medication at the onset of pain, monitoring for side effects such as dizziness and constipation, and seeking emergency care or contacting the provider for chest pain, unrelieved pain, or shortness of breath. She was advised to take pain medication approximately one hour prior to physical therapy sessions. The patient verbalized understanding through teach-back. The plan of care includes skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> at a frequency of 1 visit weekly for 12 weeks, followed by 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> weekly for 1 week, and then 1 visit weekly for 5 weeks. Physical therapy services are scheduled to begin on 01/29/26 with a frequency of 1 visit for 1 week, 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> per week for 2 weeks (Tuesday/Thursday), followed by 1 visit per week for 5 weeks (Tuesday). Occupational therapy has been ordered to assess functional needs and determine the potential need for a home health aide. The overall goal of care is to improve strength, balance, endurance, functional mobility, stair negotiation, and safety awareness to reduce fall risk and maximize the patient's independence within the home environment. <br> Date of Order 01/29/2026 Orders Physician Face-to-Face Date: 01/20/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's due to Hypertensive Heart Disease With Heart Failure Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home <br> 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes: <br> Physician Henry, Anise

## SN Careplans

SN WK1: 1 (01/29/26-01/31/26) ,WK2: 2 (02/01/26-02/07/26) ,WK3: 2 (02/08/26-02/14/26) ,WK4: 1 (02/15/26-02/21/26) ,WK5: 1 (02/22/26-02/28/26) ,WK6: 1 (03/01/26-03/07/26) ,WK7: 1 (03/08/26-03/14/26) ,WK8: 1 (03/15/26-03/21/26)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 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 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, limited endurance, Pain Interference with ADLs, balance deficit, loss of appetite

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, home exercise program, 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 medicatio, * how to maintain a diary to monitor effective and non-effective pain relief

## SN Goals

PATIENT-STATED GOAL: I WANT TO GET BETTER . I BEEN SICK FOR A LONG TIME

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 medicatio

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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

| Signature of Physician: | Date |
|---|---|
| | PAGE 2 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 01/29/2026 |

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including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxatio, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

## PT Careplans

PT WK1: 1 (01/29/26-01/31/26) ,WK2: 2 (02/01/26-02/07/26) ,WK3: 2 (02/08/26-02/14/26) ,WK4: 1 (02/15/26-02/21/26) ,WK5: 1 (02/22/26-02/28/26) ,WK6: 1 (03/01/26-03/07/26) ,WK7: 1 (03/08/26-03/14/26) ,WK8: 1 (03/15/26-03/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea

PROCEDURES: cough/deep breathing exercises, incentive spirometer, heat application: Pt instructed to apply heat to low back x 20 minutes with necessary barrier and skin assessments q 5 minutes., home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance.

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

## PT Goals

PATIENT-STATED GOAL: To be able to walk, get stronger and to eventually get back up and down steps.

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 medicatio

## OT Careplans

OT WK1: 1 (01/29/26-01/31/26) ,WK2: 1 (02/01/26-02/07/26) ,WK3: 1 (02/08/26-02/14/26) ,WK4: 1 (02/15/26-02/21/26) ,WK5: 1 (02/22/26-02/28/26) ,WK6: 1 (03/01/26-03/07/26)

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

PROCEDURES: Medication review , cough/deep breathing exercises, 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 medicatio, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent, Therapeutic exercise , Balance training , Endurance training

## OT Goals

PATIENT-STATED GOAL: to be able to perform BADLs

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 medicatio

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Therapeutic exercise

Balance training

Endurance training

| Signature of Physician: | Date |
|---|---|
| | PAGE 3 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 01/29/2026 |