Home Health Certification and Plan of Care

Order ID: 1150/16340

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
89281313	02/17/2026	From: 02/17/2026 To: 04/17/2026	21226	217058

6. Patient's Name and Address

Karen Ensor
7340 Argonne Dr,
MARRIOTTSVILLE, MD 21104-
443-909-6097

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 03/07/1944 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
J44.1	Chronic obstructive pulmonary disease w (acute) exacerbation	02/17/26

13. ICD	Other Pertinent Diagnoses	Date
J10.1	Flu due to oth ident influenza virus w oth resp manifest	02/17/26
J96.01	Acute respiratory failure with hypoxia	02/17/26
J96.02	Acute respiratory failure with hypercapnia	02/17/26
G93.40	Encephalopathy unspecified	02/17/26
J43.9	Emphysema unspecified	02/17/26
I11.0	Hypertensive heart disease with heart failure	02/17/26
I50.810	Right heart failure unspecified	02/17/26
I48.91	Unspecified atrial fibrillation	02/17/26
I89.0	Lymphedema not elsewhere classified	02/17/26
I27.20	Pulmonary hypertension unspecified	02/17/26
E78.5	Hyperlipidemia unspecified	02/17/26
E03.9	Hypothyroidism unspecified	02/17/26
F41.9	Anxiety disorder unspecified	02/17/26
F32.A	Depression unspecified	02/17/26
F43.20	Adjustment disorder unspecified	02/17/26
Z79.01	Long term (current) use of anticoagulants	02/17/26
Z86.711	Personal history of pulmonary embolism	02/17/26
Z86.718	Personal history of other venous thrombosis and embolism	02/17/26

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

Accuneb - Albuterol Sulfate 2 puffs Inhalation
Amilodipine - Amlodipine Besylate 5 mg Oral 1 time daily
Ammonium Chloride - Ammonium Chloride 12 % Topical Apply the skin
Clobetasol Propionate - Clobetasol Propionate 0.05 % Topical once to twice a day for 2 weeks Take a 2 week break between episodic use. Avoid use on face and folds
Furosemide - Furosemide 20 mg Oral nightly PRN
Cozaar - Losartan Potassium 25 mg Oral 1 time daily
Armour Thyroid - Levothyroxine Sodium 25 mcg Oral in the morning Take 1 tab daily for thyroid
Dabigatran Etexilate - Dabigatran Etexilate 0 150 mg Oral once a day Take 1 tab daily for DVT prevention.
Dutoprol - Hydrochlorothiazide: Metoprolol Succinate 12.5 mg Oral 2 times daily

14. DME and Supplies:

wheelchair, rolling walker, hand held shower, bath bench, commode, grab bars, nebulizer, reacher, walker, oxygen supplies, 4 wheeled walker

15. Safety Measures:

walker precautions, smoke detectors , , , , ambulates with device, ambulates with assistance, emergency phone # clearly displayed, supervision at all times, transfer with assist, , hand rails, , bathroom safety, , activity supervision

16. Nutrition:

low sodium, cardiac diet, 2gm sodium

17. Allergies:

penicillin

18.A. Functional Limitations

Endurance, Bowel/Bladder Incontinence, Dyspnea With Minimal Exertion, Ambulation

18.B. Activities Permitted

Walker, Transfer bed/Chair, Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

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

Homebound status: Due to diagnosis of Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation, 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 81-year-old female admitted to home health services following hospitalization and subsequent subacute rehabilitation for acute on chronic hypoxic respiratory failure in the setting of Influenza A, COPD exacerbation, new onset atrial fibrillation with rapid ventricular response, congestive heart failure with significant fluid volume overload (BNP reported at 6,000), hypertension, and urinary tract infection (resolved). Her past medical history is significant for chronic obstructive pulmonary disease (COPD), chronic heart failure (CHF), atrial fibrillation on anticoagulation therapy, pulmonary hypertension, hypertension, hyperlipidemia, hypothyroidism, history of deep vein thrombosis and pulmonary embolism (DVT/PE), and anxiety. The patient is designated as full code with a MOLST on file. All prescribed medications are present in the home. The patient is currently residing with her daughter and son-in-law in a single-family, multi-level home with a first-floor living arrangement to accommodate her needs. She has strong family support, and her daughter has organized her bed and medical supplies on the main level. The home contains two small dogs, which are secured during clinician <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh>. Upon nursing assessment, the patient was resting comfortably in a recliner on 0.5 liters of oxygen via nasal cannula. She previously required up to 3 liters of oxygen during hospitalization. She presents with +4 pitting edema to bilateral lower extremities. Education was provided extensively regarding CHF management, including the importance of daily weights, monitoring for signs and symptoms of fluid overload, proper lower extremity elevation, sodium restriction as applicable, and adherence to prescribed medications. The nurse demonstrated proper application of compression stockings and reinforced the importance of daily use to manage edema. Respiratory education included instruction on proper nebulizer use and inhaler technique, with successful return demonstration by the patient. Functionally, the patient demonstrates generalized weakness and deconditioning. Bilateral lower extremity strength is approximately 3+/5 by manual muscle testing, and bilateral upper extremity strength is 4/5. She

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/17/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Felecia Waddleton Willis
7070 Samuel Morse Dr
Columbia, MD 21046
PHONE: FAX: NPI: 1366673097

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 : 02/04/2026

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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exhibits impaired dynamic standing balance (Fair-) and decreased cardiopulmonary endurance with exertional dyspnea. She requires minimal assistance for bed mobility and contact guard assistance for sit-to-stand and toilet transfers, with verbal cueing for proper limb placement and safety. She performs upper body dressing with contact guard assistance and requires minimal assistance for lower body dressing. Bathing is currently performed at sink side. The patient ambulates approximately 40-60 feet with a rolling walker and contact guard assistance but demonstrates oxygen desaturation below 90% with exertion, requiring rest breaks and pacing. She requires one-person assistance at all times for ambulation. All necessary durable medical equipment is available in the home. The patient is considered homebound due to impaired strength, decreased endurance, oxygen dependence, high fall risk, and the considerable effort required to leave the home safely. Skilled nursing services are medically necessary for continued cardiopulmonary assessment, oxygen management, CHF education and monitoring, medication management, and reinforcement of disease management strategies to prevent exacerbation and rehospitalization. Skilled home health physical therapy is warranted for cardiopulmonary reconditioning, lower extremity strengthening, gait training, balance interventions, energy conservation techniques, and fall prevention. Occupational therapy services are indicated to address deficits in activities of daily living, upper extremity strengthening, transfer safety, and functional endurance training to promote independence with self-care tasks. The plan of care includes ongoing skilled nursing and therapy interventions focused on improving functional mobility, enhancing cardiopulmonary tolerance, managing edema, reinforcing oxygen safety, and educating the patient and family on early recognition of symptom exacerbation. The overall goal is to restore the patient to her highest level of safe functional independence while reducing the risk of rehospitalization.
 Date of Order 02/17/2026 Orders Physician Face-to-Face Date: 02/04/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat hha-adl's msw due to Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation 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 Waddleton Willis, Felecia

SN Careplans

SN WK1: 2 (02/17/26-02/21/26) ,WK3: 1 (03/01/26-03/07/26) ,WK5: 1 (03/15/26-03/21/26) ,WK7: 1 (03/29/26-04/04/26)

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, 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 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: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, swelling in the arms/legs, dependent edema, M1033 - Exhaustion, frequent urination, muscle weakness, limited endurance, limited strength, limited range of motion, balance deficit, daytime fatigue, Pain Interference with ADLs, Pain Effect on Sleep, obesity

SN Goals

PATIENT-STATED GOAL: I want to get better so I can go back to living in my own home.

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

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

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	02/17/2026

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PROCEDURES: incentive spirometer, teach/coordinate/arrange medication packaging and/or administration

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 including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxatio, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * 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, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 2 (02/17/26-02/21/26) ,WK2: 2 (02/22/26-02/28/26) ,WK3: 2 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK5: 1 (03/15/26-03/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, 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

PROCEDURES: HEP: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., Medication Review-: Patient verbalized understanding of current prescriptions, dosages, and schedule. No reported issues with adherence, side effects, or confusion at this time. , 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 - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: Not to go back to hospital

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

OT Careplans

OT WK1: 1 (02/17/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/14/26) ,WK5: 1 (03/15/26-03/21/26) ,WK6: 1 (03/22/26-03/28/26)

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: Patient/caregiver recalls related purpose and schedule of medications: Medication review , cough/deep breathing exercises, therapeutic exercises, transfers training

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Picking Up Object - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent, Patient will demonstrate improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

OT Goals

PATIENT-STATED GOAL: Patient wants to go back to being independent

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Sit to Stand - 06. Independent

Picking Up Object - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Patient will demonstrate improved bilateral upper extremity muscle strength from 4/5 mmt to 5/5 mmt to improve ADLs and transfers within 6 wks

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/17/2026