Home Health Certification and Plan of Care

Order ID: 1150/18861

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
02103032470	05/17/2026	From: 05/17/2026 To: 07/15/2026	25367	217058

6. Patient's Name and Address

Ellen Reinhardt
20 Box Hill South Parkway Apt 204,
Abingdon, MD 21009-
443-910-8213

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 03/13/1947 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I11.0	Hypertensive heart disease with heart failure	05/17/26

13. ICD	Other Pertinent Diagnoses	Date
I50.32	Chronic diastolic (congestive) heart failure	05/17/26
I48.0	Paroxysmal atrial fibrillation	05/17/26
I42.8	Other cardiomyopathies	05/17/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	05/17/26
G21.19	Other drug induced secondary parkinsonism	05/17/26
F41.9	Anxiety disorder unspecified	05/17/26
F31.9	Bipolar disorder unspecified	05/17/26
R13.11	Dysphagia oral phase	05/17/26
K59.09	Other constipation	05/17/26
M79.89	Other specified soft tissue disorders	05/17/26
I44.7	Left bundle-branch block unspecified	05/17/26
E78.5	Hyperlipidemia unspecified	05/17/26
H81.10	Benign paroxysmal vertigo unspecified ear	05/17/26
E21.3	Hyperparathyroidism unspecified	05/17/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	05/17/26
Z95.810	Presence of automatic (implantable) cardiac defibrillator	05/17/26
Z91.81	History of falling	05/17/26
Z79.01	Long term (current) use of anticoagulants	05/17/26
Z79.82	Long term (current) use of aspirin	05/17/26
Z87.440	Personal history of urinary (tract) infections	05/17/26
Z87.891	Personal history of nicotine dependence	05/17/26

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

ELIQUIS 5 mg oral twice a day for stroke prevention
ASPIRIN 81 mg oral every day delayed release tablet
LIPITOR 20 mg oral every day
VITAMIN 125 Microgram oral every day
FUROSEMIDE 20 mg oral every day
HYDRALAZINE 25 mg oral 3 times a day for 30 Day(s) FOR BLOOD PRESSURE
LAMOTRIGINE 100 mg oral 2 times a day
LISINOPRIL 40 mg oral every day FOR BLOOD PRESSURE
MECLIZINE 25 mg oral 3 times a day as needed for dizziness
MELATONIN 10 mg oral one a day (at bedtime)
METOPROLOL 25 mg oral an 1/PO 2x/day extended release
MIRTAZAPINE 15 mg oral once a day (at bedtime)
PANTOPRAZOLE 40 mg oral 2 times a day for 30 Day(s) 1 hour before eating
METAMUCIL 3.4 g of 7 g oral every day powder for reconstitution

14. DME and Supplies:

bath bench, grab bars, wheelchair, walker, commode, 4 wheeled walker

15. Safety Measures:

walker precautions, smoke detectors , medication safety, fall precautions, bleeding precautions, ambulates with device, transfer with assist, supervision at all times, ambulates with assistance, wheelchair precautions, standard precautions, hand rails, cardiac precautions, bathroom safety, anticoagulant precautions, activity supervision

16. Nutrition:

soft, diabetic

17. Allergies:

no known allergies

18.A. Functional Limitations

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

18.B. Activities Permitted

Walker, 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: 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

SN:family/caregiver will be responsible for managing treatment
PT:patient will be responsible for managing treatment
OT: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:

Patient is a 79-year-old female with a past medical history significant for chronic atrial fibrillation on anticoagulation therapy, nonischemic cardiomyopathy status post implantable cardioverter-defibrillator (ICD) placement, congestive heart failure, hypertensive heart disease, hypertension, left bundle branch block, arteriosclerotic heart disease, benign paroxysmal positional vertigo (BPPV), recurrent urinary tract infections, hyperlipidemia, Parkinson's disease, anxiety, bipolar disorder, depression, constipation, ambulatory dysfunction, chronic dizziness/vertigo, and recurrent falls. Patient was referred for skilled home health and rehabilitation services following recent hospitalization and subacute rehabilitation stay secondary to multiple falls and worsening dizziness. In April, patient experienced a fall at home without head trauma or fractures and was admitted to Upper Chesapeake Hospital for further evaluation. CT scan of the head revealed an old small occipital cerebrovascular accident without acute intracranial findings. Patient subsequently transferred to Sterling Rehabilitation Facility from 04/10/2026 through 04/30/2026 for physical therapy, strengthening, and functional mobility training prior to discharge home. During hospitalization and rehabilitation stay, echocardiogram demonstrated preserved left ventricular ejection fraction estimated at 50-55% with dilated left atrium consistent with known nonischemic cardiomyopathy. Blood pressure remained persistently elevated throughout rehabilitation course. Medication reconciliation identified incorrect administration of metoprolol succinate 37.5 mg twice daily, which has since been corrected to once-daily dosing. Hydralazine dosage was increased from 25 mg twice daily to 25 mg three times daily for improved blood pressure management. Patient reports Lasix has been discontinued and she is no longer taking the medication. Current medication regimen includes metoprolol succinate 37.5 mg daily, hydralazine 25 mg three times daily, Eliquis 5 mg twice daily for atrial fibrillation and secondary stroke prevention, atorvastatin, meclizine as needed for vertigo, and psychiatric medications including mirtazapine and lamotrigine. Patient remains on

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/17/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Mathew Feely
12 Medstar Blvd Ste 220
Bel Air, MD 21015
PHONE: 4108778088 FAX: 14108778082 NPI: 1447813647

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 : 05/08/2026

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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anticoagulation therapy and is at increased fall and bleeding risk requiring close monitoring. Patient currently resides alone in a senior apartment with elevator access. Prior to recent hospitalization, patient was independent with bed mobility, transfers, ambulation using a rolling walker, activities of daily living, and basic self-care tasks, with daughter assisting primarily with ordering adaptive devices as needed. Since hospitalization and rehabilitation stay, patient demonstrates impaired balance, gait dysfunction, decreased standing tolerance, reduced bilateral upper extremity strength, generalized weakness, decreased activity tolerance, dizziness, and transfer deficits contributing to decline in functional independence and increased fall risk. Patient currently requires assistance and supervision with functional ambulation, transfers, and self-care tasks due to impaired endurance, weakness, and safety concerns. Lower extremity edema is present and requires ongoing monitoring. Patient has been instructed to elevate lower extremities when seated and to comply with daily weight monitoring and fluid status assessment for management of congestive heart failure symptoms. Cardiopulmonary status, edema, dyspnea, and signs of fluid overload will continue to be closely monitored following discontinuation of Lasix. Skilled nursing services remain medically necessary for ongoing assessment and management of chronic medical conditions including hypertension, congestive heart failure, atrial fibrillation, anticoagulation therapy, edema monitoring, dizziness, medication management, fall prevention, and cardiopulmonary assessment. Daily blood pressure monitoring, daily weights, cardiac/low-sodium diet, and medication reconciliation have been implemented. Skilled physical therapy is indicated to address balance deficits, gait instability, lower extremity weakness, transfer training, endurance, strengthening, and fall prevention strategies to improve safe mobility and reduce risk of rehospitalization. Skilled occupational therapy is also recommended to address deficits in standing tolerance, upper extremity strength, activity tolerance, self-care performance, functional transfers, and activities of daily living with the goal of returning patient to prior level of function. Fall precautions remain in place, and patient was educated regarding safety awareness, proper use of assistive devices, hydration, energy conservation, edema management, and compliance with medication and therapy recommendations. Follow-up with primary care physician and cardiology services has been recommended for continued management of chronic cardiac and neurologic conditions.
 Date of Order 05/17/2026 Orders Physician Face-to-Face Date: 05/08/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management, pt-eval & treat, ot-eval & treat 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
 1 - SOC - SN Notes: soc OT Eval Notes: PT Eval Notes:
 Physician Feely, Mathew

SN Careplans

SN WK1: 1 (05/17/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26)

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, 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:MOLST form present

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, M1610 - Urinary Incontinence

PROCEDURES: cough/deep breathing exercises, incentive spirometer, teach/coordinate/arrange medication packaging and/or administration

SN Goals

PATIENT-STATED GOAL: Patient states she wants to be able to walk without falling with her walker

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
* 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
* 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

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	05/17/2026

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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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (05/17/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26)

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 : Medication reviewed, home exercise program: Seated hip flexion, laq, heelraises, hip abduction, standing hip extension, hamstring curls, hip flexion, heelraises., equipment training, work simplification/energy conservation, dynamic standing balance exercises: Focus wt shifting improving reaction time., 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, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, 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, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To improve balance and walking and not fall anymore

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

1 - Step (curb) - 05. Setup or clean-up assistance

Shower/Bathe Self - 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

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

OT Careplans

OT WK2: 1 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26) ,WK4: 1 (06/07/26-06/13/26)

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 with all medications in the home, home exercise program: Bilateral UE strengthening of anterior deltoid, biceps, triceps and pectoral muscles, equipment training, work simplification/energy conservation, strengthening exercises: Skilled OT 1x5wks, assist with bathing: Skilled OT 1x5wks, assist with transferring: Skilled OT 1x5wks, assist with lower body dressing: Skilled OT 1x5wks

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 - 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: Get in the shower;Get in the shower

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

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

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/17/2026