Home Health Certification and Plan of Care

Order ID: 1150/11760

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
41269944	08/23/2025	From: 08/23/2025 To: 10/21/2025	16080	217058

6. Patient's Name and Address

Patrick Connolly
44 Tommy True Ct,
PARKVILLE, MD 21234-
410-665-8335

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 09/26/1957 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	08/23/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	08/23/25
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	08/23/25
M41.86	Other forms of scoliosis lumbar region	08/23/25
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	08/23/25
E78.5	Hyperlipidemia unspecified	08/23/25
Z79.1	Long term (current) use of non-steroidal non-inflam (NSAID)	08/23/25
Z87.891	Personal history of nicotine dependence	08/23/25

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

Proscar - Finasteride 5 mg, Take 1 tablet by mouth once a day
Flomax - Tamsulosin Hydrochloride 0.4 mg, Take 2 capsules by mouth at bedtime Take 2 capsules by mouth daily at bedtime
Lipitor - Atorvastatin Calcium 20 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily For cholesterol and heart protection
Omega 3 - Cod Liver Oil Tab 1 by mouth once a day 2 tabs
Magnesium Hydroxide - Magnesium Hydroxide 500mg by mouth once a day Supplement
Aspirin 81Mg - Aspirin 81mg by mouth twice a day
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 4 hours 1-2 tabs for post surgical pain
Colace - Docusate Sodium 100mg by mouth twice a day 1-2 tabs for stool softners
Loratidine - Loratadine 5mg by mouth once a day Allergies
Joint and muscle support Tab by mouth once a day Supplement
Azelastine - Azelastine Hydrochloride 205.5mcg nasal as necessary
Triamcinolone - Triamcinolone 0.1% topical as necessary
Budesonide - Budesonide 32mcg nasal as necessary

14. DME and Supplies:

walker

15. Safety Measures:

bleeding precautions, infectious material management, bathroom safety, medication safety, supervision at all times, standard precautions, hip precautions, fall precautions, anticoagulant precautions, ambulates with assistance, activity supervision

16. Nutrition:

low cholesterol

17. Allergies:

penicillin

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Walker, 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: No

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

patient will be responsible for managing treatment
another facility/provider will be responsible for managing treatment

Homebound status: After undergoing Right Total Hip Replacement, 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 status post right total hip replacement under the care of Dr. Huang and currently utilizes a walker for safety and fall prevention. He is alert and oriented x4, reporting postoperative pain rated at 8/10, though he denies dizziness, lightheadedness, nausea, vomiting, urinary discomfort, or recent falls. His last bowel movement was two days ago, with no associated abdominal discomfort, and he reports an adequate appetite. The patient resides in a single-family home with support from his ex-wife and currently sleeps on the living room couch. Physical assessment revealed clear lung sounds, and the patient successfully demonstrated use of the incentive spirometer. Education was provided regarding hydration for prevention of constipation, dehydration, and infection; pain management including medication use and ice therapy; and wound care, emphasizing keeping the dressing dry and contacting the surgeon if increased bruising, pain, or swelling occurs. Medications were reviewed with the patient and caregiver for understanding. No abnormal bleeding or additional wounds were noted. Functionally, the patient performed supine heel slides and hip abduction/adduction with assistance, seated long arc exercises, standing marching, and heel raises (10 repetitions x 2). Stair negotiation and proper heel-to-toe gait pattern with walker use were also taught. The plan includes ongoing skilled nursing visits for dressing removal, incision site assessment, measurement, and photo documentation.
 Date of Order 08/23/2025 Orders Physician Face-to-Face Date: 08/07/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Hip Replacement 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: PT Eval Notes: Physician Huang , James

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 08/23/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

James Huang
8028 Ritchie Hwy
Pasadena, MD 21122
PHONE: 410-737-5600 FAX: 14107375391 NPI: 1154567709

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 : 08/07/2025

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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SN WK1: 1 (08/23/25-08/23/25) ,WK2: 1 (08/24/25-08/30/25)

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: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 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; 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 ; 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 the pt's incision and on post op day 12-14 the nurse or physical therapist will remove the patient's staples and leave OTA., 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.

Keep dressing clean and dry
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, frequent urination, limited range of motion, limited strength, swelling of affected area, Pain Interference with Therapy activities, B1000 - Vision Deficit, balance deficit, pain radiating to arms/legs, difficulty sleeping, Pain Interference with ADLs, Pain Effect on Sleep, bruising/discoloration, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Hip -

PROCEDURES: Discharge from Skilled Nursing- Do DISCHARGE SUMMARY- SN communication note, Medication Review- : Medications reviewed with patient/caregiver., cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: To right hip surgical site- keep dressing clean and dry. 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.

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, * low cholesterol dietary guidelines, 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * how to promote optimized mobility with strength balance dexterity range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing prevent constipation, related medication(s) purpose, schedule, * how to incorporate lifestyle modifications to optimize genito-urinary condition including diet exercise home remedies, 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, meal preparation is available to patient for all meals

PATIENT-STATED GOAL: To walk normal and decrease pain

GOALS
patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to incorporate lifestyle modifications to optimize genito-urinary condition including diet
* exercise
* home remedies
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to promote optimized mobility with strength
* balance
* dexterity
* range-of-motion therapeutic exercises
* promotion of peripheral circulation
* fluid and diet intake to promote healing
* prevent constipation
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* low cholesterol dietary guidelines
* recalls related medication(s) purpose, schedule

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
* 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

meal preparation is available to patient for all meals

PT Careplans	PT Goals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	08/23/2025

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PT WK2: 3 (08/24/25-08/30/25) ,WK3: 3 (08/31/25-09/06/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, Pain Interference with ADLs, Pain Effect on Sleep, GG0170J1 - Walk 50 ft with 2 Turns, GG0130A1 - Eating, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0130B1 - Oral Hygiene, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing

PROCEDURES: Medication Review: The medication was reviewed with patient , THR exercises: Ankle pumps, heel slides, marching, long arc , heel raises --10x2 reps , cough/deep breathing exercises, equipment training, gait training on uneven surfaces, gait training/stair training, 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 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, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, 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

PATIENT-STATED GOAL: To walk straight with out device

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

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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

Eating - 06. Independent

Car Transfer - 06. Independent

Picking Up Object - 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

Walk 10 Feet - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Sit to Stand - 06. Independent

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

Don/Doff Footwear - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	08/23/2025