Home Health Certification and Plan of Care

Order ID: 1150/11815

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01249588	08/27/2025	From: 08/27/2025 To: 10/25/2025	16087	217058

6. Patient's Name and Address
Marilyn Jennings
5902 Glen Arm Rd East,
TOWSON, MD 21057-
410-960-8266

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 10/23/1943 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	08/27/25

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	08/27/25
N39.41	Urge incontinence	08/27/25
I70.0	Atherosclerosis of aorta	08/27/25
M17.0	Bilateral primary osteoarthritis of knee	08/27/25
E55.9	Vitamin D deficiency unspecified	08/27/25
E03.9	Hypothyroidism unspecified	08/27/25
E78.5	Hyperlipidemia unspecified	08/27/25
K21.9	Gastro-esophageal reflux disease without esophagitis	08/27/25
J45.909	Unspecified asthma uncomplicated	08/27/25
F32.A	Depression unspecified	08/27/25
Z85.828	Personal history of other malignant neoplasm of skin	08/27/25
Z85.038	Personal history of malignant neoplasm of large intestine	08/27/25
Z85.068	Personal history of malignant neoplasm of small intestine	08/27/25
Z86.0100	Personal history of colonic polyps	08/27/25
Z87.891	Personal history of nicotine dependence	08/27/25
Z96.643	Presence of artificial hip joint bilateral	08/27/25

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

Lipitor - Atorvastatin Calcium 80 mg, Take 1 tablet by mouth once a day Cholesterol
Pepcid - Famotidine 20 mg, Take 1 tablet by mouth twice a day Gerd
Levothyroxine - Levothyroxine Sodium 75 mcg, Take 1 tablet by mouth in the morning Thyroid
Neurontin - Gabapentin 100 mg, Take 1 to 2 capsules by mouth at bedtime Take 1 to
2
capsules
by mouth
at night. Nerve pain
Zoloft - Sertraline Hydrochloride 25 mg, Take 1 tablet by mouth once a day Depression
Cozaar - Losartan Potassium 25 mg, Take 1 tablet by mouth once a day BP
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, 1 tablet by mouth every 4 hours As needed for pain
Aspirin 81Mg - Aspirin 81 mg, Take 1 tablet by mouth twice a day Blood thinner
Colace - Docusate Sodium 100 mg , Take 1 tablet by mouth twice a day Stool softener
Advil - Ibuprofen 200 mg Take 1 to 4 tablet s by mouth every 8 hours As needed for pain
Tylenol Arthritis - Acetaminophen 650mg take 1.5 mg by mouth every 8 hours As needed for pain
Sanctura - Trospium Chloride 20 mg take 1 tablet by mouth twice a day IBS

14. DME and Supplies:
bath bench, walker, cane

15. Safety Measures:
standard precautions, fall precautions, ambulates with device, walker precautions, medication safety, hip precautions, bathroom safety, anticoagulant precautions

16. Nutrition:
low sodium

17. Allergies:
demerol keflex tagamet lisinopril

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
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: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

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 Surgery, 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 with a past medical history significant for hypertension, duodenal cancer, abnormal gait, left hip joint pain, muscle spasms, and prior right total hip replacement. She is now status post left total hip replacement (THR). The patient is alert and oriented x4, with vital signs within normal limits. No respiratory distress was noted. Lungs are clear to auscultation bilaterally, and bowel sounds are active. The surgical site on the left hip is covered with a Mepilex dressing, which is to remain in place until the seventh postoperative day. She reports fatigue and pain rated at 5/10 but denies nausea, vomiting, shortness of breath, dizziness, or lightheadedness. Mild postoperative edema is present at the surgical site. The patient ambulates with a cane for household mobility but currently requires a rolling walker for safety and stability. She completed therapeutic exercises during this session including ankle pumps, hamstring stretches, heel slides, assisted straight leg raises, and hip abduction/adduction in supine; long arc quadriceps in sitting; and marching and heel raises in standing, performing two sets of ten repetitions each. She was also trained in heel-to-toe gait sequencing with a rolling walker. Education was provided on pain management strategies, safe ambulation techniques, fall prevention, medication compliance, use of ice for swelling and pain relief, and constipation prevention. The patient demonstrated understanding and verbalized agreement with the plan of care. Family members are actively involved in her care and supportive of her recovery. The patient continues to experience postoperative pain and edema but is progressing with mobility training and exercise tolerance. Ongoing skilled nursing and physical therapy visits are recommended to monitor her recovery, reinforce education, and promote safe mobility, strength, balance, and independence in activities of daily living.
 Date of Order 08/27/2025 Orders Physician Face-to-Face Date: 08/19/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Hip Replacement Surgery Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home <span

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 08/27/2025

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 : 08/19/2025

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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 1 - SOC - SN Notes: PT Eval Notes: Physician Huang , James

SN Careplans

SN WK1: 1 (08/27/25-08/30/25) ,WK2: 1 (08/31/25-09/06/25)

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

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, abnormal thyroid <> 0.40 - 4.50 mIU/mL, heartburn/indigestion, M1610 - Urinary Incontinence, frequent urination, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, loss of appetite, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Left Hip -

PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: Left hip surgical site: remove Mepilex dressing on the 7th day post op and LOTA, otherwise cover with a dry gauze., bladder training

TEACH PATIENT/CAREGIVER: * 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, * 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

SN Goals

PATIENT-STATED GOAL: To walk without 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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
* 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

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles SN RN

Date

08/27/2025

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PT WK1: 2 (08/27/25-08/30/25) ,WK2: 3 (08/31/25-09/06/25) ,WK3: 1 (09/07/25-09/13/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, Pain Interference with ADLs, GG0170I1 - Walk 10 Feet, 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, GG0170J1 - Walk 50 ft with 2 Turns, GG0130B1 - Oral Hygiene, 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 the patient , THR Exercises : Heel slides, hamstring stretching, slr, long arc , marching, and 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 - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 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

PATIENT-STATED GOAL: To walk straight with out pain

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

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Car Transfer - 06. Independent

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching 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

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

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

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

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

Sit to Stand - 06. Independent

4 Steps - 04. Supervision or touching assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles SN RN

Date
08/27/2025