

Home Health Certification and Plan of Care				Order ID: 1150/11963	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
16199474		09/04/2025		From: 09/04/2025 To: 11/01/2025	
4. Medical Record No.		5. Provider No.			
16440		217058			
6. Patient's Name and Address Juneat Carpintieri 3611 Glenarm Ave, BALTIMORE, MD 21206- 443-909-6553			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 10/18/1965 9.Sex Female			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
11. ICD Z47.1	Principal Diagnosis Aftercare following joint replacement surgery	Date 09/04/25	Roxicodone - Oxycodone Hydrochloride 5 mg, Take 1 tablet by mouth every 4 hours Take 1 tablet by mouth every 4 hours as needed for pain (1-2 tablets as needed)		
13. ICD Z96.642 M17.12 I10. E55.9 K58.9 E78.1 H04.123 R32. R73.03 E66.9 Z68.31 Z79.82 Z90.710	Other Pertinent Diagnoses Presence of left artificial hip joint Unilateral primary osteoarthritis left knee Essential (primary) hypertension Vitamin D deficiency unspecified Irritable bowel syndrome without diarrhea Pure hyperglyceridemia Dry eye syndrome of bilateral lacrimal glands Unspecified urinary incontinence Prediabetes Obesity unspecified Body mass index [BMI] 31.0-31.9 adult Long term (current) use of aspirin Acquired absence of both cervix and uterus	Date 09/04/25 09/04/25 09/04/25 09/04/25 09/04/25 09/04/25 09/04/25 09/04/25 09/04/25 09/04/25 09/04/25 09/04/25 09/04/25	Ecotrin - Aspirin 81 mg, Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day for 28 days Esidrix - Hydrochlorothiazide 25 mg, Take 1 tablet by mouth in the morning Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpantenol: Folic Acid: Niacinamide: Pyridox 50 mcg (2,000 unit) , Take 1 tablet by mouth once a day Colace - Docusate Sodium 100 mg , Take 1 capsule by mouth twice a day Take 1 capsule by mouth 2 times a day		
14. DME and Supplies: rolling walker			15. Safety Measures: fall precautions, standard precautions, walker precautions, medication safety, hip precautions, bleeding precautions, bathroom safety, aspiration precautions, anticoagulant precautions		
16. Nutrition: high fiber, regular			17. Allergies: allegra benadryl		
18.A. Functional Limitations Ambulation			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: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No		
20. Prognosis:			good		
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: 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		
Homebound status: After undergoing Left 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: <div>The patient is a 59-year-old with a recent left total hip replacement and a medical history of hypertension, osteoarthritis, hyperlipidemia, and newly diagnosed diabetes with a recent HbA1c of 6.6. The patient is not currently taking prescribed Lipitor and will follow up with the primary care provider for updated blood work. The patient ambulates indoors with a rolling walker for 30 feet twice, requiring supervision and verbal cues for gait pattern, and performs transfers to the toilet, bed, and chair with supervision. Bed mobility also requires supervision. Outdoor mobility, car transfers, and stair negotiation were not assessed at this time. The patient lives in a ranch-style home with her husband, requiring navigation of four steps with a railing to enter, and is considered homebound due to significant effort required to leave the home, further supported by a Tinetti score of 14/28. The patient tolerated therapeutic exercises including hip flexion, bridging, quad sets, gluteal sets, knee extensions, and ankle pumps (10 repetitions each). Education was provided on proper medication adherence and elevating the left leg above heart level. The patient would benefit from continued home therapy to improve strength, mobility, and overall independence.</div><div> </div><div></div><div>Date of Order</div><div>09/04/2025</div><div><div>Orders</div><div>Physician Face-to-Face Date: 08/07/2025</div><div>Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left Total Hip Replacement</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div> </div><div></div><div><div>1 - SOC - SN Notes:</div><div>PT Eval Notes:</div><div>Physician</div><div>Huang , James</div></div>					
SN Careplans			SN Goals		
SN WK1: 1 (09/04/25-09/06/25) ,WK2: 1 (09/07/25-09/13/25)			PATIENT-STATED GOAL: Pain decrease ;Make sure my hip doesn't pop out		
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			GOALS patient/caregiver recalls		
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance			* how to achieve wound healing including cleaning and dressing wound		
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			* position changes		
			* skin care		
			* diet modification		
			* record wound measurements		
			* recalls related medication(s) purpose, schedule		
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles SN RN on 09/04/2025				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. PAGE 1 of 3		

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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: M1720 - Anxiety, meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, constipation, poor muscle tone, muscle weakness, limited strength, limited range of motion, limited endurance, swelling of affected area, Pain Effect on Sleep, Pain Interference with ADLs, Pain Interference with Therapy activities, obesity, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Left Hip - PROCEDURES: MEDICATION REVIEW: Medications reviewed at every visit. , cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: To left hip surgical site- 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, * 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, * lifestyle modifications low-residue dietary guidelines alternative medicine options for ulcerative colitis, related medication(s) purpose, schedule, * how to keep journal of food and fluid intake healthy meal plan tips exercise program nutritional knowledge, 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, MEDICATION REVIEW	patient/caregiver recalls * lifestyle modifications * low-residue dietary guidelines * alternative medicine options for ulcerative colitis * recalls related medication(s) purpose, schedule patient/caregiver recalls * how to keep journal of food and fluid intake * healthy meal plan tips * exercise program * nutritional knowledge * 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 * prevention exacerbation of anxiety condition including coping patterns * improved concentration * strategies to reduce anxiety * identification of anxiety precipitants, conflicts, and threats * 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 MEDICATION REVIEW
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PT Careplans PT WK1: 1 (09/04/25-09/06/25) ,WK2: 3 (09/07/25-09/13/25) ,WK3: 2 (09/14/25-09/20/25) PROBLEMS IDENTIFIED ON ASSESSMENT: 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: Home exercise program : Supine quad sets, glut sets, hip flexion, bridging, hip abduction. Standing knee flexion, hip abduction, plantarflexion, squats. Sitting knee extension, ankle pumps , Bed mobility training , Hip precautions training, equipment training, gait training on uneven surfaces, gait training/stair training, transfers training	PT Goals PATIENT-STATED GOAL: Walk independently without pain using a cane GOALS Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance 1 - Step (curb) - 05. Setup or clean-up assistance Toilet Transfer - 06. Independent 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
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/04/2025

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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, Oral Hygiene - 06. Independent, Lower Body Dressing - 03. Partial/moderate assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 06. Independent, Car Transfer - 04. Supervision or touching assistance, 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		Car Transfer - 04. Supervision or touching 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 Lower Body Dressing - 03. Partial/moderate assistance Shower/Bathe Self - 03. Partial/moderate assistance Don/Doff Footwear - 03. Partial/moderate assistance Sit to Stand - 04. Supervision or touching assistance Chair to Bed to Chair - 04. Supervision or touching assistance Walk 10 Feet - 05. Setup or clean-up assistance Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Eating - 06. Independent		

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