Home Health Certification and Plan of Care

Order ID: 1150/12380

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
97217360	09/20/2025	From: 09/20/2025 To: 11/18/2025	17044	217058

6. Patient's Name and Address

Margaret Hollidge
910 Langley Rd,
GLEN BURNIE, MD 21060-
443-683-0878

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 11/02/1945 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	09/20/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	09/20/25
J43.9	Emphysema unspecified	09/20/25
I35.0	Nonrheumatic aortic (valve) stenosis	09/20/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	09/20/25
K75.4	Autoimmune hepatitis	09/20/25
D84.9	Immunodeficiency unspecified	09/20/25
E78.00	Pure hypercholesterolemia unspecified	09/20/25
M85.80	Oth disrd of bone density and structure unspecified site	09/20/25
F17.210	Nicotine dependence cigarettes uncomplicated	09/20/25
R91.8	Other nonspecific abnormal finding of lung field	09/20/25
E66.01	Morbid (severe) obesity due to excess calories	09/20/25
Z68.33	Body mass index [BMI] 33.0-33.9 adult	09/20/25
Z79.52	Long term (current) use of systemic steroids	09/20/25

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

Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg; 1-2 tabs by mouth every 4 hours as needed for pain
Lipitor - Atorvastatin Calcium eq 80 mg base 80 mg Oral Tab/Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for cholesterol and stroke protection
Tiotropium-Olodaterol (STIOLTO RESPIMAT) 2.5-2.5 mcg/Inhale 2 puffs inhalant once a day Inhale 2 puffs by mouth daily

COPD
Imuran - Azathioprine 50 mg 50 mg Oral Tab/Take half table by mouth once a day Take half tablet by mouth daily
AUTOIMMUNE HEPATITIS
Acetaminophen - Acetaminophen 500MG; 2 TABS by mouth every 6 hours AS NEEDED FOR PAIN
Colace - Docusate Sodium 100MG; 1 TAB by mouth once a day BOWEL REGIMEN
Asa 81 Mg - Aspirin 81MG; 1 TAB by mouth twice a day ANTIPLATELET
Albuterol (PROAIR/PROVENTIL/VENTOLIN) 90 mcg/Inhale 2 puffs inhalant every 4-6 hours Inhale 2 puffs by mouth every 6 hours as needed (Rescue inhaler)
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25 MCG; 1 TAB by mouth once a day SUPPLEMENT

14. DME and Supplies:

bath bench, wound care supplies, cane, walker

15. Safety Measures:

infectious material management, , , ambulates with device, walker precautions, hip precautions, ,

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Cane, Walker, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, 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

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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 09/20/2025

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 : 08/14/2025

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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Clinical Condition Requiring Homecare:

The patient is a 79-year-old female, status post right total hip replacement (RTHR) performed on 09/18/25 via anterior approach, weight bearing as tolerated. Past medical history includes immunocompromised status secondary to medications, aortic valve stenosis, chronic autoimmune hepatitis, emphysema, COPD, obesity, coronary artery disease, and arthritis. She returned home the same day of surgery with continuous family support. Skilled nursing frequency is 1w2, and physical therapy evaluation and treatment were initiated. On assessment, the patient was alert and oriented 3, denied shortness of breath, and demonstrated clear lung sounds. She reported minimal pain, currently managed with oxycodone and acetaminophen, though she expressed dislike of oxycodone. Education was provided regarding pain management, including taking medication at the onset of pain, potential side effects such as dizziness and constipation, and recommendations to take analgesics one hour prior to PT sessions. She was advised to contact her physician (Dr. Huang) to discuss alternative pain management options. Appetite was reported as good, and her last bowel movement occurred prior to surgery. The right hip dressing was intact without drainage, and incision care education was reviewed. No drainage, redness, or signs of infection were noted. The patient presented with decreased endurance, strength, and mobility, limited stair negotiation, unsteady gait, decreased safety awareness, and a history of falls-all contributing to increased fall risk. Functional mobility assessment revealed that she required minimal assistance to stand-by assistance for transfers using a rolling walker, with verbal cues for hand and foot placement, weight shifting, and reaching back before sitting. Ambulation on level surfaces with a walker required standby assistance, with cues provided for walker positioning and improved right step length and height. She was instructed to use the walker at all times and to initiate a walking program, starting with short walks every 1-2 hours in the home and gradually progressing to longer ambulation sessions as tolerated. Therapeutic interventions included supine exercises (ankle pumps, quadriceps sets, gluteal sets, 20 repetitions each; assisted right heel slides, 10 repetitions), with a copy of the home exercise program provided for twice-daily completion. Passive range of motion of the right hip was performed in supine position. Ice application instructions were reviewed (20 minutes with skin checks every 5 minutes), and the importance of daily ambulation for circulation and prevention of complications was emphasized. Patient and caregiver were educated on anterior hip precautions (avoid combined hip flexion with external rotation and combined hip extension with external rotation), edema management strategies (elevation of lower extremities, potential compression if ordered), signs and symptoms of infection, home safety, and fall-prevention strategies. A copy of the patient handbook (pg. 32-33) was reviewed, covering risk factors and safety measures. The patient verbalized understanding of all teaching. Plan of care includes continued skilled nursing for post-operative monitoring, incision surveillance, and medication management; home PT at a frequency of 3w2 beginning 09/22/25, with transition to outpatient PT on 10/03/25; and surgical follow-up with Dr. Huang on 10/02/25. The patient and caregiver agreed with the PT plan of care and goals, which focus on improving strength, mobility, balance, transfer safety, and endurance to restore functional independence while reducing fall risk.
 Date of Order 09/20/2025 Orders Physician Face-to-Face Date: 08/14/2025 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
 1 - SOC - SN Notes: soc PT Eval Notes: eval Physician Huang , James

SN Careplans

SN WK1: 1 (09/20/25-09/20/25) ,WK2: 1 (09/21/25-09/27/25)

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; 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/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.

RIGHT HIP
Advance Directive:Living Will

SN Goals

PATIENT-STATED GOAL: TO WALK BETTER

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
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* diet
* weight-bearing exercises to promote bone healing and strengthening
* fluids to prevent constipation
* home safety
* pain control
* 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 including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, M1600 - UTI, limited endurance, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, bruising/discoloration, #1 - Non-Observable Surgical Wound - Anterior Right Hip - NO DRAINAGE NOTED AQUACEL DRESSING INTACT

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , Discharge Summary- Complete Discharge Summary SN communication note. , cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: To right 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 cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, related medication(s) purpose, schedule, * diet weight-bearing exercises to promote bone healing and strengthening fluids to prevent constipation home safety pain control, 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, meal preparation is available to patient for all meals

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

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 3 (09/21/25-09/27/25) ,WK3: 3 (09/28/25-10/04/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, 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: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, Seated-LAQ pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, leg curls., therapeutic modalities: Pt instructed to apply ice to R hip x 20 minutes with necessary barrier and skin assessments q 5 minutes., gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention

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 - 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 - 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

PT Goals

PATIENT-STATED GOAL: I want to be able to walk with my cane

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

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 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

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Car Transfer - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Sit to Stand - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Eating - 06. Independent

Chair to Bed to Chair - 04. Supervision or touching assistance

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

Signature of Physician:	Date
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4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

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