Home Health Certification and Plan of Care

Order ID: 1150/12500

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
68308858	09/17/2025	From: 09/17/2025 To: 11/15/2025	16811	217058

6. Patient's Name and Address

Tereasa Boone Brown
3600 W Franklin St Apt 11B,
BALTIMORE, MD 21229-
443-902-5350

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 11/19/1975 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	09/17/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	09/17/25
I10.	Essential (primary) hypertension	09/17/25
E11.9	Type 2 diabetes mellitus without complications	09/17/25
G40.909	Epilepsy unsp not intractable without status epilepticus	09/17/25
E78.5	Hyperlipidemia unspecified	09/17/25
J45.909	Unspecified asthma uncomplicated	09/17/25
G47.19	Other hypersomnia	09/17/25
F31.81	Bipolar II disorder	09/17/25
K50.90	Crohn's disease unspecified without complications	09/17/25
G43.E19	Chronic migraine with aura intractable without stat migr	09/17/25
F43.12	Post-traumatic stress disorder chronic	09/17/25
G47.00	Insomnia unspecified	09/17/25
F41.9	Anxiety disorder unspecified	09/17/25
K21.9	Gastro-esophageal reflux disease without esophagitis	09/17/25
R51.9	Headache unspecified	09/17/25
E66.01	Morbid (severe) obesity due to excess calories	09/17/25
Z68.30	Body mass index [BMI] 30.0-30.9 adult	09/17/25
Z79.899	Other long term (current) drug therapy	09/17/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	09/17/25
Z90.49	Acquired absence of other specified parts of digestive tract	09/17/25
Z98.2	Presence of cerebrospinal fluid drainage device	09/17/25
Z90.710	Acquired absence of both cervix and uterus	09/17/25

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

Miralax - Polyethylene Glycol 3350 17 gram/dose Powder by mouth once a day Take by mouth daily
Protonix - Pantoprazole Sodium 40 mg , Take 1 tablet by mouth once a day Take 1 tablet by mouth daily 30 to 60 minutes prior to a meal
Belbuca - Buprenorphine Hydrochloride 300 mcg , Place 1 film inside your cheek by mouth every 12 hours Place 1 film inside your cheek every 12 hours. Hold film to cheek for a minimum of 10 seconds to help adhere. Make sure cheek is wet prior to placing film to help film adhere. Let film dissolve completely. Do not chew film.
Asa - Aspirin 81mg by mouth once a day To stop blood clots
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg by mouth every 4 hours As needed for incision pain
Lipitor - Atorvastatin Calcium 20 mg, Take 1 tablet by mouth at bedtime Take 1 tablet by mouth daily For cholesterol and heart protection
Norvasc - Amlodipine Besylate 10 MG , Take 1 tablet by mouth once a day Take 1 tablet by mouth daily Blood pressure
Toprol Xl - Metoprolol Tartrate 50 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily Blood pressure
Risperdal - Risperidone 0.5 mg , Take 2 tablets by mouth at bedtime Take 2 tablets by mouth daily at bedtime
Phenergan - Promethazine Hydrochloride 12.5 mg , Take 1 tablet by mouth every 6 hours Take 1 tablet by mouth every 6 hours as needed for nausea or vomiting
Depakote - Divalproex Sodium 250 mg , Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day
Topamax - Topiramate 100 mg tablet, Take 2 tablets by mouth twice a day Take 2 tablet by mouth 2 times a day
Glucophage Xr - Metformin Hydrochloride 500 mg tablet, Take 2 tablet by mouth twice a day Take 2 tablet by mouth 2 times a day
Diflucan - Fluconazole 150 mg , Take 1 tablet by mouth once a day Take 1 tablet by mouth one time
Desyrel - Trazodone Hydrochloride 100 mg , Take 2 tablets by mouth at bedtime Take 2 tablets by mouth at bedtime as needed for sleep
Acetaminophen - Acetaminophen 500mg 2 tablets by mouth every 6 hours Take as needed for incision pain.

14. DME and Supplies:

walker, cane

15. Safety Measures:

infectious material management, , walker precautions, , hip precautions, , diabetic precautions, bathroom safety, ambulates with device

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

clonazepam adhesive taple amitriptyline iv dye metoclopramine hydrocloride m

18.A. Functional Limitations

18.B. Activities Permitted

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 09/17/2025

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 : 08/26/2025

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.

Home Health Certification and Plan of Care

Order ID: 1150/12500

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
68308858	09/17/2025	From: 09/17/2025 To: 11/15/2025	16811	217058

6. Patient's Name and Address
Tereasa Boone Brown
3600 W Franklin St Apt 11B,
BALTIMORE, MD 21229-
443-902-5350

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

Ambulation

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: 1. In new or complex situations only, SOCIAL ISOLATION: 3. Often, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

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: 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

Homebound status: After undergoing Total Left Hip Arthroplasty, 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 a 49-year-old female admitted to home health following a total left hip arthroplasty. Her past medical history is significant for epilepsy, Crohn's disease, aseptic necrosis of both hips, asthma, bipolar disorder, type 2 diabetes mellitus, chronic headache, and chronic back pain. She is alert and oriented to person and place with intermittent orientation to time. The patient reports pain rated 7/10 with movement; she last received analgesia at 12:00 PM and endorses intermittent dizziness after taking opioid pain medication-opioid use education was provided. She denies shortness of breath, chest pain, or lightheadedness. Vitals were obtained, the surgical site was assessed, medications were reviewed, and patient education was completed. The patient reports no bowel movement at present and is using a stool softener. Functional deficits were identified in endurance, dynamic standing balance, strength, range of motion, and overall mobility. She stands and transfers independently but requires increased time and currently requires a rolling walker (RW) for ambulation; ambulation is performed with supervision and demonstrates an antalgic, step-to pattern. A Timed Up and Go (TUG) was completed in 1:23, indicating high fall risk. A home exercise program (HEP) including supine therapeutic exercises, sit-to-stand practice, and hourly ambulation was reviewed. Daughter and fianc were present during the visit. The patient is an appropriate candidate for skilled therapy services to address identified deficits and promote a safe return to prior level of function.
 Date of Order 09/17/2025 Orders Physician Face-to-Face Date: 08/26/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Total Left Hip Arthroplasty 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 (09/17/25-09/20/25) ,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

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

SN Goals

PATIENT-STATED GOAL: I want to feel better and move around more.

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 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
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

Signature of Physician:

Date

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

Date
09/17/2025

Home Health Certification and Plan of Care

Order ID: 1150/12500

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
68308858	09/17/2025	From: 09/17/2025 To: 11/15/2025	16811	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Tereasa Boone Brown 3600 W Franklin St Apt 11B, BALTIMORE, MD 21229- 443-902-5350	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

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: D0160 - Depression, D0700 - Social Isolation, M2020 - Oral Med Management, M1400 - Dyspnea, limited endurance, swelling of affected area, limited strength, limited range of motion, Pain Effect on Sleep, Pain Interference with ADLs, difficulty sleeping, balance deficit, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Left Hip - , #2 - Observable Surgical Wound - Anterior Left Thigh -

PROCEDURES: Medication review : Review medications with patient/caregiver at each 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule

PT Careplans

PT WK1: 2 (09/17/25-09/20/25) ,WK2: 3 (09/21/25-09/27/25) ,WK3: 1 (09/28/25-10/04/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Effect on Sleep, 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: Therapeutic exercise , Dynamic standing balance , Medication Review- Medications reviewed with patient/caregiver., gait training on uneven surfaces, gait training/stair training, transfers 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, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 03. Partial/moderate 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, Medication Review- Patient/caregiver, related purpose and schedule of medications.

PT Goals

PATIENT-STATED GOAL: To walk independently

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Car Transfer - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Sit to Stand - 06. Independent

Medication Review- Patient/caregiver recalls related purpose and schedule of medications.

Shower/Bathe Self - 03. Partial/moderate 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

Eating - 06. Independent

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up 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

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/17/2025