Home Health Certification and Plan of Care

Order ID: 1150/12554

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
24158895	09/24/2025	From: 09/24/2025 To: 11/22/2025	17096	217058

6. Patient's Name and Address
Joanette Jones
3044 W North Ave,
BALTIMORE, MD 21216-
443-500-9368

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 11/23/1964 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	09/24/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	09/24/25
M17.12	Unilateral primary osteoarthritis left knee	09/24/25
M16.11	Unilateral primary osteoarthritis right hip	09/24/25
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	09/24/25
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	09/24/25
N18.31	Chronic kidney disease stage 3a	09/24/25
M54.17	Radiculopathy lumbosacral region	09/24/25
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	09/24/25
M48.061	Spinal stenosis lumbar region without neurogenic claud	09/24/25
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	09/24/25
E55.9	Vitamin D deficiency unspecified	09/24/25
E66.9	Obesity unspecified	09/24/25
Z68.32	Body mass index [BMI] 32.0-32.9 adult	09/24/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	09/24/25
Z87.891	Personal history of nicotine dependence	09/24/25
Z90.710	Acquired absence of both cervix and uterus	09/24/25

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

Sitagliptin Phosphate - Sitagliptin Phosphate 100 mg, Take 1 tablet by mouth once a day Taken1x daily for diabetes
Cymbalta - Duloxetine Hydrochloride 60 mg 60 mg, Take 1 capsule by mouth once a day Pt reports taking it for nerve pain in her legs
8-Hour Bayer - Aspirin 81mg by mouth in the morning Pt does not know med indication but takes it as instructed.
Neurontin - Gabapentin 300 mg 300 mg, Take 1 capsule by mouth three times a day Per patient; takes 1 in the morning and 2 at night
Prinivil - Lisinopril 10 mg 10 mg, Take 1 tablet by mouth once a day Taken every morning for HBP
Lipitor - Atorvastatin Calcium eq 40 mg base 40 mg, Take 1 tablet by mouth once a day Taken 1x daily for high cholesterol
Flexeril - Cyclobenzaprine Hydrochloride 10 mg, Take 1 tablet by mouth three times a day Take 1 tablet by mouth 3 times a day as needed for muscle spasms or pain
Alphacaine - Lidocaine 4 % Top PTMD Patch, Apply 1 Patch topical once a day Apply 1 Patch to skin daily as needed (pain) , may remain in place for up to 12 hours in a 24-hour period
Voltaren - Diclofenac Sodium 1 % Top Gel, Apply 4 g to affected area(s) topical four times a day Apply 4 g to affected area(s) 4 times a day as needed for pain (OTC Product)
Basaglar - Insulin Glargine 28 units subcutaneous in the morning Admistered daily for diabetes 1x daily before breakfast
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 4 hours Post surgical pain
Extra Strength Tylenol - Acetaminophen 500mg by mouth every 4-6 hours

14. DME and Supplies:
grab bars

15. Safety Measures:
transfer with assist, walker precautions, smoke detectors , , restricted ROM, non-slip surface in tub, no straining, no reaching, no lifting, diabetic precautions, emergency phone # clearly displayed, , hand rails, hip precautions, , ambulates with device, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
metformin

18.A. Functional Limitations
None of the above

18.B. Activities Permitted
Partial Weight Bearing, Up As Tolerated, Cane, Walker

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: 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 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 09/24/2025

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 : 09/05/2025

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 60-year-old female, alert and oriented 4, recently discharged on September 23, 2025, following a total left hip replacement. Past medical history includes osteoarthritis of the left hip and knee, with noted genu valgus deformity of the left knee. She reports no current pain, rating it 0/10, though she describes mild numbness at the incision site. She is prescribed a very low dose of oxycodone for pain management and reports adherence. Vital signs are stable, lung sounds are clear bilaterally, pedal pulses are strong, and there is no edema noted in either lower extremity. Appetite and oral intake are adequate, bowel movements are regular without constipation, and she denies nausea, vomiting, or other gastrointestinal complaints. Sleep is described as fair. The surgical site remains covered with a sterile dressing per surgeon's instructions, with no removal or wetting until her scheduled follow-up appointment next week. Due to this restriction, the incision could not be directly assessed today; however, a photograph of the dressing has been uploaded to the chart for documentation. The patient is compliant with wearing compression stockings on the left lower extremity to reduce DVT risk. She ambulates indoors with a rolling walker for up to 30 feet under supervision and cues for gait pattern. Transfers to bed, chair, and toilet require supervision, and she has notable difficulty rising from the toilet, requiring a commode. Bed mobility requires moderate assistance to lift the left leg, with reinforcement of hip precautions. She has not yet been assessed on outdoor ambulation, stair navigation, or car transfers. The patient demonstrates decreased strength and endurance, with homebound status confirmed by significant exertion required to leave her home and supported by a Tinetti score of 14/28. Therapeutic exercises completed today included knee extensions, ankle pumps, quadriceps sets, gluteal sets, hip flexion, and bridging, tolerated at 10 repetitions each. She was instructed in the application of ice to the left hip for 20 minutes several times per day and advised to elevate the left leg above heart level to assist with pain and edema management. Education was also reinforced on medication management, safety precautions, and the importance of maintaining hip precautions. The patient resides in an elevator-accessible apartment with her boyfriend, who assists with household tasks and provides support with ADLs and IADLs. She currently performs sink baths per post-operative instructions. She expresses motivation to progress in therapy, with her primary goal being to regain strength and safely return to her occupation as a one-on-one caregiver. Plan: Continue skilled nursing 1w3 for monitoring of pain, mobility, and wound status; reinforce safety and medication education; and proceed with ongoing PT/OT services to improve strength, balance, and functional independence. Follow-up with the surgeon is scheduled for dressing change next week.
 Date of Order 09/24/2025 Orders Physician Face-to-Face Date: 09/05/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Total Left 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 (09/24/25-09/27/25) ,WK2: 1 (09/28/25-10/04/25)

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: 2. Non-agency caregiver(s) need training/supportive services to 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.

; 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: M2020 - Oral Med Management, meal preparation, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, muscle weakness, limited range of motion, muscle spasms, limited endurance, limited strength, Pain Interference with Therapy activities, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Anterior Left Hip - Pt denies pain at surgical site

SN Goals

PATIENT-STATED GOAL: "I want to be able to work again"

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 manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* 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 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
* 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
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/24/2025

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PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , Discharge Summary- Complete Discharge Summary SN communication note. , cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, 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., glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration

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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, 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 manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

* recalls related medication(s) purpose, schedule

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 2 (09/24/25-09/27/25) ,WK2: 3 (09/28/25-10/04/25) ,WK3: 1 (10/05/25-10/11/25)

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: Home exercise program : Supine quad sets, glut sets, hip flexion, bridging, 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

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

PT Goals

PATIENT-STATED GOAL: Walk independently without pain using a cane

GOALS
Toilet Transfer - 06. Independent

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

1 - Step (curb) - 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

Shower/Bathe Self - 03. Partial/moderate 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

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

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

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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