# Home Health Certification and Plan of Care

**Order ID: 1150/12857**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 48224594 | 09/30/2025 | From: 09/30/2025 To: 11/28/2025 | 17240 | 217058 |

**6. Patient's Name and Address**
Robert Ourand
508 Oak Wood Station,
GLEN BURNIE, MD 21061-
443-960-5233

**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** 06/28/1966 **9.Sex** Male

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| Z47.1 | Aftercare following joint replacement surgery | 09/30/25 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| Z96.641 | Presence of right artificial hip joint | 09/30/25 |
| I10. | Essential (primary) hypertension | 09/30/25 |
| K21.9 | Gastro-esophageal reflux disease without esophagitis | 09/30/25 |
| H52.4 | Presbyopia | 09/30/25 |

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

Tylenol - Acetaminophen 500 mg , Take 2 tablets by mouth three times a day Take 2 tablets
by mouth 3
times a day
as needed for
pain
Mobic - Meloxicam 15 mg , Take 1 tablet by mouth once a day Take 1 tablet
by mouth
daily
Norvasc - Amlodipine Besylate 5 mg , Take 1 tablet by mouth once a day Take 1 tablet
by mouth
daily
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg by mouth every 4 hours
Colace - Docusate Sodium 100mg by mouth twice a day Prevent constipation
Aspirin 81Mg - Aspirin 81 by mouth twice a day

**14. DME and Supplies:**
wound care supplies, 4 wheeled walker

**15. Safety Measures:**
infectious material management, hip precautions, , ambulates with device

**16. Nutrition:**
Z. NO PHYSICIAN-ORDERED DIET

**17. Allergies:**
no known allergies

**18.A. Functional Limitations**
Dyspnea With Minimal Exertion, Ambulation

**18.B. Activities Permitted**
Walker, 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: 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 Right 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:** The patient is a 59-year-old male with a past medical history significant for hypertension and arthritis involving the right knee and shoulder. He is status post right total hip replacement (THR) performed on September 29, 2025. The patient returned home the same day following the procedure and currently resides with assistance from his friend, Tammy, who works primarily from home and is available to provide support as needed. Postoperatively, the patient exhibits decreased endurance and mobility, contributing to an increased risk of falls. He demonstrates deficits in right hip strength, functional mobility, transfer ability, and balance, as well as difficulty negotiating steps and maintaining safety awareness during ambulation.  On assessment, the patient was alert and oriented 4, denying chest pain, palpitations, or dizziness. Lung sounds were clear to auscultation bilaterally, though mild shortness of breath was noted upon exertion. His last bowel movement was yesterday, with normoactive bowel sounds and normal voiding without complications. +1 pedal edema was noted, and pedal pulses were palpable bilaterally. The surgical dressing to the right hip was clean, dry, and intact with no drainage observed; it is scheduled for removal seven days post-procedure. A wound photo and measurement were obtained for baseline documentation.  The patient was educated on the signs and symptoms of infection, medication actions and side effects, and postoperative precautions, including total hip precautions-avoiding hip flexion beyond 90 degrees, refraining from crossing legs, and avoiding pivoting on the operated leg while standing. The patient verbalized understanding of all instructions and demonstrated appropriate receptiveness to education.  A physical therapy (PT) evaluation was completed, and the plan of care (POC) was developed in collaboration with the patient and his caregiver. Both agreed with the outlined therapy goals and schedule. The patient will receive home physical therapy three times weekly for two weeks (3w2) starting September 30, 2025, to focus on improving strength, endurance, functional mobility, balance, and safety during transfers and ambulation. He is expected to transition to outpatient physical therapy beginning October 13, 2025, with a postoperative follow-up appointment scheduled with Dr. Huang on October 14, 2025. Skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-visits">visits</mh> will continue for wound monitoring, medication management, and reinforcement of education regarding infection prevention and pain control. The plan of care emphasizes promoting recovery, preventing complications, and restoring the patient's independence in activities of daily living while maintaining safety at home. <br> Date of Order 09/30/2025 Orders Physician Face-to-Face Date: 09/10/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Hip Replacement Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home <br> 1 - SOC - SN Notes: soc PT Eval Notes: eval <br> Physician Huang , James

**SN Careplans**

**SN Goals**

**23. Signature and Date of Verbal SOC Where Applicable:**
Electronically Signed by Messick, Charles SN RN on 09/30/2025

**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 : 09/10/2025

**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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SN WK1: 1 (09/30/25-10/04/25) ,WK2: 1 (10/05/25-10/11/25)

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: 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 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, $SpO_2$: 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, abnormal blood pressure, constipation, swelling of affected area, limited endurance, limited range of motion, limited strength, Pain Interference with Therapy activities, B1000 - Vision Deficit, balance deficit, Pain Interference with ADLs, Pain Effect on Sleep, discolored patches of skin, bruising/discoloration, #1 - Non-Observable Surgical Wound - Anterior Right Hip -

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: 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/coordinate/arrange medication packaging and/or administration

TEACH PATIENT/CAREGIVER: * how to take the patient's blood pressure record the reading, 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, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PATIENT-STATED GOAL: I want 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
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

| PT Careplans | PT Goals |
|---|---|
| | |

| Signature of Physician: | Date |
|---|---|
| | PAGE 2 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles SN RN | 09/30/2025 |

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PT WK1: 3 (09/30/25-10/04/25) ,WK2: 3 (10/05/25-10/11/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170G1 - Car Transfer, 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, GG0170I1 - Walk 10 Feet, GG0130B1 - Oral Hygiene, 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, assisted R heel slide and assisted R hip abd. Seated-LAQ, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, leg curls., therapeutic modalities: Pt instructed to apply ice to R hip x 20 minutes with necessary barrier and skin assessments q 5 minutes., equipment training: Use of 3WW, cane, gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention

TEACH PATIENT/CAREGIVER: 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 - 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

PATIENT-STATED GOAL: I want to get back to being independent

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

Chair to Bed to Chair - 06. Independent

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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Car Transfer - 06. Independent

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

Eating - 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

Toileting Hygiene - 06. Independent

Sit to Stand - 06. Independent

Oral Hygiene - 06. Independent

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Signature of Physician:

Date



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

Date
09/30/2025