Home Health Certification and Plan of Care

Order ID: 1150/13069

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
98280135	10/08/2025	From: 10/08/2025 To: 12/06/2025	17467	217058

6. Patient's Name and Address

Susan Grim
1104 Oakland Terrace,
HALETHORPE, MD 21227-
410-916-9645

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 07/06/1965 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	10/08/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	10/08/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	10/08/25
E78.019	Familial hypercholesterolemia	10/08/25
E78.5	Hyperlipidemia unspecified	10/08/25
G89.4	Chronic pain syndrome	10/08/25
M41.9	Scoliosis unspecified	10/08/25
F11.20	Opioid dependence uncomplicated	10/08/25
Z79.02	Long term (current) use of antithrombotics/antiplatelets	10/08/25
Z79.82	Long term (current) use of aspirin	10/08/25
Z90.49	Acquired absence of other specified parts of digestive tract	10/08/25
Z86.718	Personal history of other venous thrombosis and embolism	10/08/25
Z87.891	Personal history of nicotine dependence	10/08/25

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

Crestor - Rosuvastatin Calcium 40 mg 40 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily to prevent heart attack and stroke
Toprol-Xl - Metoprolol Succinate eq 25 mg tartrate 25 mg ,Take 1 tablet by mouth once a day HTN
Ecotrin - Aspirin 81 mg , Take 1 tablet by mouth once a day PROPHYLACTIC
Narcan - Naloxone Hydrochloride 4 mg/actuation Nasl Spray,Spray in 1 nostril if not breathing/responding. Call 911. If still not breathing/responding, use new spray in 2 to 3 minutes in other nostril. Nasal once a day Spray in 1 nostril if not breathing/responding. Call 911. If still not breathing/responding, use new spray in 2 to 3 minutes in other nostril. For suspected opioid overdose use only
Colace - Docusate Sodium 100 mg, Take 100 mg tablet by mouth once a day BOWEL REGIMEN
Plavix - Clopidogrel Bisulfate eq 75 mg base 75 mg ,Take 1 tablet by mouth once a day Take 1 tablet by mouth daily Take through 11/2025 (one year after stent)
Replaces brilinta
Methadose - Methadone Hydrochloride 10 mg/mL Oral Conc,Take 0.25 mL by mouth once a day Take 0.25 mL by mouth daily 115mg
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5MG; 1 -2 TABS by mouth every 4 hours AS NEEDED FOR PAIN

14. DME and Supplies:

rolling walker, wound care supplies, cane, bath bench

15. Safety Measures:

infectious material management, hip precautions, standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, ambulates with assistance, transfer with assist, anticoagulant precautions

16. Nutrition:

cardiac diet

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Cane, Up As Tolerated, Walker, Exercises Prescribed

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: 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 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.

Clinical Condition Requiring Homecare:

The patient is a 60-year-old female admitted to home health services following a left anterior hip replacement. Her past medical history includes deep vein thrombosis (DVT) post-spinal surgery, coronary artery disease (CAD), hyperlipidemia (HLD), and a severe opioid use disorder currently managed with methadone. The patient resides in a multilevel home with her spouse, who assists with all activities of daily living (ADLs) and instrumental ADLs as needed. Prior to surgery, the patient was independent without assistive devices. Durable medical equipment (DME) in use includes a rolling walker (RW), single point cane (SPC), shower chair (SC), and bedside commode (BSC). The home environment includes three steps at the entrance and 14 stairs to access the second-floor bedroom. On assessment, the patient was alert and oriented to person, place, and time, and reported pain at 5/10, managed effectively with oxycodone. Lungs were clear with no signs of shortness of breath. The left hip surgical dressing was intact with no drainage noted. Physical therapy evaluation indicated limitations in strength, range of motion, endurance, balance, ADLs, and overall functional mobility. The Timed Up and Go (TUG) test was completed in 2:03, indicating a high risk for falls. A home exercise program (HEP) including supine and seated therapeutic exercises was reviewed, with both patient and spouse demonstrating understanding. The patient was educated on the importance of ice, elevation, and use of TED hose to manage edema. Skilled nursing reviewed all medications, including dosing, frequency, indications, and side effects, and provided education on effective pain management. The patient will benefit from continued skilled therapy services to promote a safe return to prior level of function (PLOF).<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 10/08/2025
 Order<o:p></o:p> <p

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 10/08/2025

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 : 09/25/2025

27. Attending Physician's Signature and Date Signed **10/14/2025** 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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class="MsoNoSpacing">Physician Face-to-Face Date: 09/25/2025
 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval Notes: <o:p></o:p> Physician: Huang, James

SN Careplans

SN WK1: 1 (10/08/25-10/11/25) ,WK2: 1 (10/12/25-10/18/25)

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, 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; 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, M1400 - Dyspnea, limited endurance, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, #1 -
Non-Observable Surgical Wound - Anterior Left Hip -

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , Discharge Summary- Complete Discharge Summary SN communication note. , cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, 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 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, * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, 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 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

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
* 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 peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	10/08/2025

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PT Careplans

PT WK1: 2 (10/08/25-10/11/25) ,WK2: 3 (10/12/25-10/18/25) ,WK3: 1 (10/19/25-10/25/25)

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

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

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Sit to Stand - 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

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

Shower/Bathe Self - 03. Partial/moderate assistance

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

Signature of Physician:

Date

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

Date
10/08/2025