Home Health Certification and Plan of Care

Order ID: 1150/13216

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
91282023	10/18/2025	From: 10/18/2025 To: 12/16/2025	14206	217058

6. Patient's Name and Address

Marcus Hughes
7725 Hornbeam Dr Unit 233,
ELKRIDGE, MD 21075-
301-653-8372

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 02/03/1977 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	10/18/25

13. ICD	Other Pertinent Diagnoses	Date
J45.20	Mild intermittent asthma uncomplicated	10/18/25
E78.5	Hyperlipidemia unspecified	10/18/25
D64.9	Anemia unspecified	10/18/25
B35.1	Tinea unguium	10/18/25
R73.03	Prediabetes	10/18/25
Z79.82	Long term (current) use of aspirin	10/18/25
Z96.643	Presence of artificial hip joint bilateral	10/18/25
Z87.891	Personal history of nicotine dependence	10/18/25

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

Colace - Docusate Sodium 100mg by mouth twice a day Constipation
Aspirin 81Mg - Aspirin 81 by mouth once a day Due to procedure
Tylenol - Acetaminophen 500 mg Oral Tablet by mouth every 8 hours Take 1 to 2
tablets by
mouth every
8 hours as
needed for
pain
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg; 1 tab by mouth every 4 hours Pain from procedure

14. DME and Supplies:

cane, bath bench, walker

15. Safety Measures:

standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, hip precautions, anticoagulant precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

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: 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 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 was admitted to home health services following a right total hip replacement. Past medical history is significant for anemia, hyperlipidemia, intermittent asthma, aseptic necrosis of bilateral hips, a history of smoking, and unhealthy alcohol use. The patient is alert and oriented 3, reports right hip pain at 8/10, and is currently taking oxycodone for effective pain relief. Lungs are clear to auscultation, and the patient denies shortness of breath. Appetite is good, and the right hip dressing remains clean, dry, and intact. The patient ambulates with a walker for safety and receives assistance from caregivers outside the home. Skilled nursing reviewed all medications and provided education on pain management and when to notify the nurse or physician; the patient verbalized understanding. The patient is a 48-year-old male living alone in an apartment with elevator access and daily caregiver support as needed. He presents with limitations in range of motion, strength, endurance, functional mobility, and standing balance, with right lower extremity edema further limiting motion and strength. The patient currently stands and transfers independently and ambulates indoors with a rolling walker, requiring increased time. Car transfers, stairs, and outdoor ambulation were not assessed at this visit. The Timed Up and Go (TUG) test was completed in 31 seconds, indicating a high fall risk. The home exercise program was reviewed, including supine therapeutic exercises, sit-to-stand practice, and hourly ambulation. The patient will benefit from continued skilled therapy services to address functional deficits, improve strength and mobility, and promote a safe return to his prior level of function.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 10/18/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 10/03/2025
 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<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval Notes:<o:p></o:p> Physician: Huang, James

SN Careplans

SN WK1: 1 (10/18/25-10/18/25) ,WK2: 1 (10/19/25-10/25/25)

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: 10. None of the above

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

SN Goals

PATIENT-STATED GOAL: I WANT PAIN TO GET 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 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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 10/18/2025

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 : 10/03/2025

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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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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, limited range of motion, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Right Hip - DRESSING INTACT NO DRAINAGE NOTED

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 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

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

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 2 (10/19/25-10/25/25) ,WK3: 3 (10/26/25-11/01/25) ,WK4: 1 (11/02/25-11/08/25)

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: 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: 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

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

4 Steps - 05. Setup or clean-up assistance

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	10/18/2025

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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

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

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

Signature of Physician:	Date
	PAGE 3 of 3
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