Home Health Certification and Plan of Care

Order ID: 1150/13231

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
11508704320	10/18/2025	From: 10/18/2025 To: 12/16/2025	6253	217058

6. Patient's Name and Address
Michael West
817 W Cross St,
Baltimore, MD 21230-
707-312-1240

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 09/11/1963 | **9.Sex** Male

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

13. ICD	Other Pertinent Diagnoses	Date
G43.719	Chronic migraine w/o aura intractable w/o stat migr	10/18/25
E11.69	Type 2 diabetes mellitus with other specified complication	10/18/25
N52.9	Male erectile dysfunction unspecified	10/18/25
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	10/18/25
K40.90	Unil inguinal hernia w/o obst or gangr not spcf as recur	10/18/25
D64.9	Anemia unspecified	10/18/25
N20.0	Calculus of kidney	10/18/25
E53.8	Deficiency of other specified B group vitamins	10/18/25
H04.123	Dry eye syndrome of bilateral lacrimal glands	10/18/25
K21.9	Gastro-esophageal reflux disease without esophagitis	10/18/25
F32.A	Depression unspecified	10/18/25
F41.9	Anxiety disorder unspecified	10/18/25
E66.9	Obesity unspecified	10/18/25
Z68.32	Body mass index [BMI] 32.0-32.9 adult	10/18/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	10/18/25
Z79.4	Long term (current) use of insulin	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
Z89.412	Acquired absence of left great toe	10/18/25
Z89.422	Acquired absence of other left toe(s)	10/18/25
Z98.84	Bariatric surgery status	10/18/25
Z87.891	Personal history of nicotine dependence	10/18/25

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

Acetaminophen - Acetaminophen 325 mg tablet, Take 2 tablets by mouth every 6 hours as needed for MILD Pain (or if patient requests it for moderate or severe pain) or Fever (temp in PRN comment) (For fever greater than 38.0 and notify physician.)
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 mg, Take 1 tablet by mouth every 4 hours
Glipizide - Glipizide 5 MG,Take 2 tablets by mouth twice a day before meals.
What changed:
when to take this
Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here.
Diclofenac - Diclofenac Epolamine 50 MG, Take 50 mg Tablet by mouth three times a day
Gabapentin - Gabapentin 300 MG, Take 300 mg capsule by mouth three times a day
Jardiance - Empagliflozin 25 MG, Take 12.5 tablet by mouth once a day
Pantoprazole - Pantoprazole Sodium 40 mg tablet, Take 40 mg by mouth once a day
Rosuvastatin Calcium - Rosuvastatin Calcium 5 MG, Take 5 mg tablet by mouth once a day
Ceftriaxone Sodium - Ceftriaxone Sodium 500mg intravenous once a day
For infection treatment flush picc line with 10cc saline before and after
Saline Flush - Normal Saline 10 ml intravenous twice a day Flush PICC pre and post IV antibiotic administration, For PICC patency

14. DME and Supplies:
walker, diabetic supplies

15. Safety Measures:
hip precautions, walker precautions, sharps precautions, infectious material management, diabetic precautions, cardiac precautions, ambulates with device, ambulates with assistance

16. Nutrition:
diabetic

17. Allergies:
metformin ozempic statins

18.A. Functional Limitations
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: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., 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
family/caregiver 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 62-year-old male referred to home health care services following a recent right total hip replacement. His past medical history is significant for osteoarthritis, diabetes mellitus (DM), hypertension (HTN), depression, anxiety, a prior left hip replacement in 2019, left toe amputations, right second toe amputation, and migraines. The patient is alert, oriented, and cooperative during assessment. He resides in a multi-level townhouse with his wife, who was present during the visit. The home has six steps to enter, equipped with a handrail. Due to mobility limitations, the patient currently sleeps on the sofa on the first floor, which has been arranged as his primary living space. The bathroom on the same level contains a low toilet, and a commode was requested via the home health portal to improve safety and accessibility. On assessment, the alginate dressing to the right hip surgical site was intact, with no drainage or signs of infection, and is to remain in place for seven days per postoperative instructions. The patient reports no acute distress, and vital signs were stable. He ambulates indoors using a rolling walker, walking 30 feet 2 with supervision and verbal cues for proper "step-to" gait sequencing. The walker was adjusted to appropriate height for safety and posture. Bed mobility on the sofa required minimal assistance, and transfers from sitting to standing were performed under supervision. The therapist advised against sitting in the living room chair as it is too low and may compromise hip precautions. Outdoor mobility, stair climbing, and car transfers were not assessed during this visit. The patient reports not wearing TED stockings, stating they were not received upon discharge; this was documented, and the supervising nurse was notified. The patient was educated extensively on postoperative hip precautions, the importance of ambulating several times daily to prevent stiffness and thromboembolic complications, medication adherence, and the use of ice therapy multiple times per day for pain and swelling control. He verbalized understanding of all instructions. Skilled nursing services were recommended at a frequency of once weekly for four weeks

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

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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(1w4) to monitor the surgical site, assess for complications, and reinforce postoperative education. Physical therapy evaluation was ordered to focus on strengthening, gait training, endurance, and safe transfer techniques. The patient is homebound due to the taxing effort required to leave his home and a Tinetti Balance and Gait Assessment score of 14/28, indicating moderate fall risk. Ongoing goals include improving lower extremity strength, enhancing balance and functional mobility, maintaining incision integrity, and supporting a safe recovery process under coordinated interdisciplinary home health care. The next skilled nursing visit is scheduled for Wednesday.
 Date of Order 10/18/2025 Orders Physician Face-to-Face Date: 09/30/2025 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
 1 - SOC - SN Notes: soc PT Eval Notes: eval 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, blood sugar < 60 > 300

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.

; 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, M2020 - Oral Med Management, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, poor muscle tone, limited strength, swelling of affected area, muscle weakness, limited endurance, limited range of motion, obesity, #1 - Non-Observable Surgical Wound - Other - Right hip - Alginate dressing to remain in place for 7 days

PROCEDURES: Medication Review- : Medications reviewed with patient /caregiver, Discharge Summary- Complete Discharge Summary SN communication note. , cough/deep breathing exercises, 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

SN Goals

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
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* dietary guidelines for managing nutritional deficit
* 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/caregiver recalls
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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/caregiver recalls
* how to keep journal of food and fluid intake
* healthy meal plan tips
* exercise program
* nutritional knowledge
* recalls related medication(s) purpose, schedule

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

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

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changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * lifestyle modification to manage blood condition including dietary changes bleeding precautions, related medication(s) purpose, schedule, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * dietary guidelines for managing nutritional deficit, related medication(s) purpose, schedule, * how to keep journal of food and fluid intake healthy meal plan tips exercise program nutritional knowledge, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

PT Careplans

PT WK2: 3 (10/19/25-10/25/25) ,WK3: 3 (10/26/25-11/01/25)

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. Sitting knee extension, ankle pumps. Standing knee flexion, hip abduction, plantarflexion, squats , Bed mobility training , Hip precaution training : Avoid flexion less than 90 degrees, no rotation , 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 - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, 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

Lower Body Dressing - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Don/Doff Footwear - 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

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/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

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

Signature of Physician:	Date
	PAGE 3 of 3
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