Home Health Certification and Plan of Care

Order ID: 1150/13306

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
071033151	10/22/2025	From: 10/22/2025 To: 12/20/2025	18056	217058

6. Patient's Name and Address

Shelly Shields
352 Wye Rd,
ESSEX, MD 21221-
443-630-6986

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 04/16/1961 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	10/22/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.643	Presence of artificial hip joint bilateral	10/22/25
M17.10	Unilateral primary osteoarthritis unspecified knee	10/22/25
I10.	Essential (primary) hypertension	10/22/25
I73.9	Peripheral vascular disease unspecified	10/22/25
E78.00	Pure hypercholesterolemia unspecified	10/22/25
E03.9	Hypothyroidism unspecified	10/22/25
K21.9	Gastro-esophageal reflux disease without esophagitis	10/22/25
E04.1	Nontoxic single thyroid nodule	10/22/25
R91.1	Solitary pulmonary nodule	10/22/25
Z87.891	Personal history of nicotine dependence	10/22/25
Z86.018	Personal history of other benign neoplasm	10/22/25
Z79.82	Long term (current) use of aspirin	10/22/25
Z79.891	Long term (current) use of opiate analgesic	10/22/25

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

Ventolin - Albuterol 90 mcg, Inhale 2 puffs inhalant every 6 hours Inhale 2 puffs by mouth every 6 hours as needed (Rescue inhaler)
Crestor - Rosuvastatin Calcium 10 mg, Take 1 tablet by mouth once a day Take 1 tablet (10 mg total) by mouth daily
Protonix - Pantoprazole Sodium 20 mg, Take 1 tablet by mouth once a day Take 1 tablet (20 mg total) by mouth daily.
Levothyroxine (LEVOTHROID/SYNTHROID) 125 mcg, Take 1 tablet by mouth in the morning Take 1 tablet by mouth every morning 30 minutes before a meal
Acetaminophen - Acetaminophen 500mg by mouth twice a day Used as needed for pain
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth as necessary Taking as needed for pain
Colace - Docusate Sodium 100mg by mouth as necessary Laxative
Aspirin - Aspirin 81mg by mouth twice a day Blood thinner

14. DME and Supplies:

cane, walker

15. Safety Measures:

hip precautions, infectious material management, , , ambulates with device, , , hand rails, , ambulates with assistance, walker precautions, smoke detectors , restricted ROM

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Walker, Cane, Up As Tolerated

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
another facility/provider will be responsible for managing treatment

Homebound status: After undergoing Total Right 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 64-year-old female, alert and oriented times four, residing with her husband in a single-family home. She was recently discharged from the hospital following a total right hip replacement performed on Monday. Prior to surgery, she ambulated with a cane due to chronic right hip pain. At present, she reports mild, manageable postoperative discomfort rated at 2/10. Her medical history includes hypertension, hyperlipidemia, gastroesophageal reflux disease (GERD), hypothyroidism, and opioid dependency, all currently stable. The patient expresses satisfaction with her recovery progress and reports that she is able to ambulate within the home with the use of a walker and some assistance from her husband, who assists mainly with meal preparation and heavier household tasks. Physical <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> reveals clear lung sounds bilaterally with unlabored respirations. The patient reports normal bowel function, with her last bowel movement occurring yesterday. Appetite is good, and she denies nausea, vomiting, or constipation. The right hip surgical incision is covered with an Aquacel dressing showing a small amount of dried blood without active drainage, swelling, or odor. Surrounding skin is intact, without redness or warmth. The patient was educated on wound care and instructed to monitor for signs of infection, including increased redness, swelling, drainage, or fever, and to report these promptly. She verbalized understanding of the education

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 10/22/2025

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 : 10/08/2025

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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provided. The patient demonstrates good comprehension of her prescribed medication regimen, including the purpose, dosage, and schedule, and reports full compliance. Physical therapy interventions were performed with the patient in various positions. In the supine position, she completed heel slides and assisted right hip abduction and adduction exercises. While seated, she performed long arc quadriceps exercises, and in standing, she practiced marching and heel raises. The patient was trained in the safe use of a walker, emphasizing a heel-to-toe gait pattern for optimal mobility and balance. Education was also provided on the proper use of ice for pain and edema management, and she demonstrated understanding of these instructions. Overall, the patient is recovering well postoperatively, with pain well controlled, no signs of infection or complications, and active participation in her rehabilitation plan. A follow-up visit is scheduled for next Monday to continue monitoring progress and functional mobility.
 Date of Order 10/22/2025 Orders Physician Face-to-Face Date: 10/08/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Total Right 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 (10/22/25-10/25/25) ,WK2: 1 (10/26/25-11/01/25)

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: 0. No assistance needed - patient is independent or does not have needs in this area

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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: A1250 - Lack of Necessary Transportation, meal preparation, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M1400 - Dyspnea, muscle weakness, limited range of motion, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B0200 - Hearing Deficit, B1000 - Vision Deficit, #1 - Non-Observable Surgical Wound - Anterior Right Hip - If the wound is draining through the dressing, it can be removed, and dry dressings applied as necessary to keep wound dry. Aquacel / Mepilex dressing stays on wound for 7 days. When dressing is removed, the incision can be left open to air if not draining

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 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.

SN Goals

PATIENT-STATED GOAL: "To be able to get back to work."

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
* 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/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 keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	10/22/2025

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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, * 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 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, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, 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's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 2 (10/22/25-10/25/25) ,WK2: 3 (10/26/25-11/01/25) ,WK3: 1 (11/02/25-11/08/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, Pain Interference with ADLs, Pain Effect on Sleep, GG0170J1 - Walk 50 ft with 2 Turns, 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, GG0130B1 - Oral Hygiene, GG0170I1 - Walk 10 Feet, 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: THR EXERCISES: Ankle pumps, heel slides, slr, long arc, marching , and heel raises --functional mobility gait training, Medication R eview: The medication was reviewed with the patient , cough/deep breathing exercises, incentive spirometer, equipment training, gait training on uneven surfaces, gait training/stair training, transfers training

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, 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

PT Goals

PATIENT-STATED GOAL: To get back to work

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

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

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

1 - Step (curb) - 05. Setup or clean-up assistance

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Car Transfer - 06. Independent

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

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

Oral Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Sit to Stand - 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

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