Home Health Certification and Plan of Care

Order ID: 1150/13376

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
63233059	10/23/2025	From: 10/23/2025 To: 12/20/2025	18057	217058

6. Patient's Name and Address

Albert Mawry
234 S Ann St,
BALTIMORE, MD 21231-
410-350-9560

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 07/28/1966 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	10/23/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	10/23/25
I10.	Essential (primary) hypertension	10/23/25
J45.909	Unspecified asthma uncomplicated	10/23/25
G89.29	Other chronic pain	10/23/25
M54.50	Low back pain unspecified	10/23/25
F17.210	Nicotine dependence cigarettes uncomplicated	10/23/25
E66.9	Obesity unspecified	10/23/25
Z68.31	Body mass index [BMI] 31.0-31.9 adult	10/23/25
Z79.82	Long term (current) use of aspirin	10/23/25

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

Albuterol Inhaler - Albuterol 90 mcg, Inhale 1 Puff inhalant every 4 hours Inhale 1 Puff By Mouth Every 4 Hours As Needed For Shortness Of Breath (Rescue Inhaler) (Note: Different Manufacturer)
Neurontin - Gabapentin 100 mg 100 mg, Take 1 capsule by mouth three times a day Take 1 capsule by mouth 3 times a day as needed for pain
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg; 1-2 tabs by mouth every 4 hours as needed for pain
Viagra - Sildenafil Citrate eq 100 mg base 100 mg, Take 1 tablet by mouth as necessary Take 1 tablet by mouth as needed (sexual activity) 1 hour prior to sexual activity. Do not exceed one tablet in 24 hours
Norvasc - Amlodipine Besylate eq 5 mg base 5 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily blood pressure
Asa 81 Mg - Aspirin 81mg; 1 tab by mouth twice a day anticoagulant
Voltaren - Diclofenac Sodium 75 mg 75 mg, Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day with meals
Colace - Docusate Sodium 100mg; 1 cap by mouth twice a day stool softner
Cozaar - Losartan Potassium 100 mg 100 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily blood pressure
Tylenol - Acetaminophen 500 mg, Take 2 tablets by mouth every 8 hours Take 2 tablets by mouth every 8 hours as needed for pain

14. DME and Supplies:

walker, cane

15. Safety Measures:

bathroom safety, infectious material management, standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, hip precautions, activity supervision, anticoagulant precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

citric acid

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Walker, Exercises Prescribed

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 10/23/2025

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 **10/29/2025** 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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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:	22.B.Discharge Plans
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.	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 is a 59-year-old who was admitted to home health services following a right total hip replacement. Her past medical history includes prediabetes, chronic lower back pain, asthma, and hypertension. She is alert and oriented 3, reports pain at 2/10 after taking pain medication, denies shortness of breath, and presents with clear lung sounds. Her right hip dressing is intact with no drainage, and she is using a walker for safe ambulation. Skilled nursing reviewed her medications, provided instruction on postoperative care, pain management, and criteria for alerting the SN/MD, with the patient receptive to all instructions. During physical therapy evaluation, the patient ambulated 30 feet indoors using a rolling walker with supervision and gait cues. She performed 12 steps on stairs with a rail and cane using a step-to pattern with cues and close supervision. Transfers to sofa, chair, and raised toilet seat were completed safely with supervision. The patient lives alone in a townhouse with six steps to enter, currently set up on the first floor. She is homebound due to the significant effort required to leave her home, as evidenced by a Tinetti score of 14/28. Home therapy is recommended to improve strength, functional mobility, and independence.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 10/23/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 10/08/2025
 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 (10/23/25-10/25/25) ,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: 1. Non-agency caregiver(s) currently 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, 8. Currently reports exhaustion

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 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, M1033 - Exhaustion, M1400 - Dyspnea, limited range of motion, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, bruising/discoloration, #1 -

SN Goals

PATIENT-STATED GOAL: I WANT PAIN TO BE CONTROLLED

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

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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* 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 RN	10/23/2025

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Non-Observable Surgical Wound - Anterior Right Hip - NONREMOVABLE DRESSING INTACT NO DRAINAGE NOTE

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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, 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

PT Careplans

PT WK1: 1 (10/23/25-10/25/25) ,WK2: 3 (10/26/25-11/01/25) ,WK3: 2 (11/02/25-11/08/25)

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 abduction, hip flexion, bridging. Standing knee flexion, hip abduction, plantarflexion, squats. Sitting knee extension, ankle pumps, Bed mobility training , Hip precautions training, 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: Ambulate through my house independently and return to sleeping upstairs

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

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

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

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

Oral Hygiene - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Eating - 06. Independent

Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

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