Home Health Certification and Plan of Care

Order ID: 1150/13545

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01231555	10/27/2025	From: 10/27/2025 To: 12/24/2025	18323	217058

6. Patient's Name and Address

Dennis McGougan
4710 Park Heights Ave Apt 207,
BALTIMORE, MD 21215-
443-674-7226

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 02/12/1953 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	10/27/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	10/27/25
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	10/27/25
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	10/27/25
N18.31	Chronic kidney disease stage 3a	10/27/25
D63.1	Anemia in chronic kidney disease	10/27/25
I70.0	Atherosclerosis of aorta	10/27/25
J30.9	Allergic rhinitis unspecified	10/27/25
L73.1	Pseudofolliculitis barbae	10/27/25
M27.0	Developmental disorders of jaws	10/27/25
E66.9	Obesity unspecified	10/27/25
Z68.30	Body mass index [BMI] 30.0-30.9 adult	10/27/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	10/27/25
Z79.82	Long term (current) use of aspirin	10/27/25
Z87.891	Personal history of nicotine dependence	10/27/25

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

Fluticasone - Fluticasone Furoate 50 mcg, Use 1 Spray nasal once a day Use 1 Spray in each nostril daily
Seroquel - Quetiapine Fumarate 100 mg , Take 1 tablet by mouth at bedtime Take 1 tablet by mouth daily at night
Prior treatment for bipolar d/o
Astelin - Azelastine Hydrochloride 137 mcg (0.1 %), Use 1 spray nasal twice a day Use 1 spray in each nostril 2 times a day
Omega-3 - Cod Liver Oil take 1,000 mg, Capsule by mouth as necessary
Lipitor - Atorvastatin Calcium eq 80 mg base 80 MG , Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for cholesterol
Glucophage - Metformin Hydrochloride 500 mg 500 Mg, Take 1 Tablet by mouth in the morning Take 1 tablet by mouth every morning with a meal
Norvasc - Amlodipine Besylate eq 5 mg base 5 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily
Lisinopril - Lisinopril 20 mg, Take 2 tablets by mouth once a day Take 2 tablets by mouth daily for high blood pressure and kidney protection
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth as necessary Taken as needed for sleep
Extra Strength Tylenol - Acetaminophen 500 by mouth as necessary Taken as needed for pain
Docusate Sodium - Docusate Sodium 100 by mouth once a day Stool softner
Aspirin 81Mg - Aspirin 81 mg , take 1 tablet by mouth once a day 1 tab PO Daily

14. DME and Supplies:

cane

15. Safety Measures:

bathroom safety, , , , infectious material management, , hip precautions, ambulates with device, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

shellfish

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Up As Tolerated, Independent at Home, None of the above, Other, Walker, Cane

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: 1. Rarely, 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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 10/27/2025

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 : 10/15/2025

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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Homebound status: After undergoing Right Total Hip Arthroplasty, 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 72-year-old male, alert and oriented 4, residing alone in a senior apartment complex with regular assistance from his son for care needs. He is status post right total hip arthroplasty (R THA) and reports right hip pain rated 3/10, which he states is well controlled with his current medication regimen. The patient shared that before surgery, chronic right hip pain significantly limited his mobility; however, he remained largely independent in his daily activities and attended the gym five days per week. His medical history includes type 2 diabetes mellitus with stage 3 chronic kidney disease, hypertension, osteoarthritis of the right hip, atherosclerosis of the aorta, and anemia. Upon <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was observed ambulating with a rolling walker, demonstrating a steady gait and proper use of the assistive device without signs of distress. Adjustments were made to the walker height, and verbal cues were provided to promote upright posture and trunk extension during ambulation. He currently requires contact guard assistance for transfers and short-distance ambulation. Strength <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> revealed decreased right lower extremity muscle strength at 3-/5 on manual muscle testing. The right hip surgical incision was covered with a clean, dry dressing with no signs of redness, swelling, drainage, or infection; surrounding skin was intact. Vital signs were stable, and the patient appeared comfortable and cooperative throughout the visit. The patient demonstrates good medication knowledge and adherence. He was educated on proper incision care and instructed to monitor for signs of infection, including redness, drainage, swelling, or fever, and to promptly report any such changes. Education was reinforced regarding the importance of adhering to his home exercise program, maintaining safe ambulation practices with his walker, and gradually increasing activity as tolerated. He verbalized understanding of all instructions provided. The patient was initiated on bilateral lower extremity therapeutic exercises focusing on ankle and knee movements to promote circulation, strength, and mobility. Hip exercises were deferred due to limited tolerance at this stage of recovery. The patient is scheduled to begin skilled physical therapy services aimed at improving right lower extremity strength, balance, endurance, and functional mobility to facilitate a safe return to his prior level of function and independence. The patient remains stable, motivated, and optimistic regarding his recovery, with no complications noted at this time.
 Date of Order 10/27/2025 Orders Physician Face-to-Face Date: 10/15/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Hip Arthroplasty 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: 2 (10/27/25-11/01/25)

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: 2. Non-agency caregiver(s) need training/supportive services to 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: meal preparation, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M1400 - Dyspnea, limited endurance, limited range of motion, limited strength, Pain Interference with Therapy activities, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Anterior Right Hip -

SN Goals

PATIENT-STATED GOAL: "To walk with only the cane or without it"

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
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* 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
* oral care
* strategies to achieve optimum nutrition
* control oral pain/discomfort
* range of motion exercises to optimize jaw mobility

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

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

10/27/2025

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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/coordinate/arrange medication packaging and/or administration

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 modification to manage blood condition including dietary changes bleeding precautions, 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, * oral care strategies to achieve optimum nutrition control oral pain/discomfort range of motion exercises to optimize jaw mobility, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 3 (10/27/25-11/01/25) ,WK2: 3 (11/02/25-11/08/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, 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: Medication Review- : medications reviewed with patient/caregiver, Instruct patient in R hip precautions including no hip flexion > 90 degrees, no hip crossing, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training, therapeutic exercises

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 - 05. Setup or clean-up assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 1 - Step (curb) - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Medication Review-

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

GOALS
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

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Eating - 06. Independent

Sit to Stand - 04. Supervision or touching assistance

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

Toilet Transfer - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Medication Review-

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 - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching

1 - Step (curb) - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Car Transfer - 04. Supervision or touching assistance

Signature of Physician:

Date

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

Date
10/27/2025