Home Health Certification and Plan of Care

Order ID: 1150/13554

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
95268225	10/29/2025	From: 10/29/2025 To: 12/27/2025	18223	217058

6. Patient's Name and Address

Herman Walker
713 N Augusta Ave,
BALTIMORE, MD 21229-
410-624-6798

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 10/24/1955 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	10/29/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	10/29/25
E11.9	Type 2 diabetes mellitus without complications	10/29/25
I10.	Essential (primary) hypertension	10/29/25
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	10/29/25
I34.1	Nonrheumatic mitral (valve) prolapse	10/29/25
D17.9	Benign lipomatous neoplasm unspecified	10/29/25
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	10/29/25
G56.01	Carpal tunnel syndrome right upper limb	10/29/25
K21.9	Gastro-esophageal reflux disease without esophagitis	10/29/25
E78.5	Hyperlipidemia unspecified	10/29/25
E66.01	Morbid (severe) obesity due to excess calories	10/29/25
Z68.37	Body mass index [BMI] 37.0-37.9 adult	10/29/25
Z79.82	Long term (current) use of aspirin	10/29/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	10/29/25
Z90.49	Acquired absence of other specified parts of digestive tract	10/29/25
Z93.3	Colostomy status	10/29/25
Z87.891	Personal history of nicotine dependence	10/29/25

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

Lipitor - Atorvastatin Calcium eq 40 mg base 40 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily cholesterol
Aspirin 81Mg - Aspirin Take 81 mg, tablet by mouth once a day Take 81 mg by mouth
Glucophage Xr - Metformin Hydrochloride 500 mg 500 mg, Take 1 tablet by mouth in the morning Take 1 tablet by mouth every morning for diabetes
Zoloft - Sertraline Hydrochloride eq 50 mg base 50 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for depression
Aldactone - Spironolactone 50 mg 50 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily fluid pill
Catapres - Chlorthalidone: Clonidine Hydrochloride 0.1 mg 0.1 mg, Take 2 tablets by mouth twice a day Take 2 tablets by mouth 2 times a day blood pressure
Cephalexin - Cephalexin eq 500 mg base 500mg; 1 cap by mouth every 8 hours anitbiotic for 14 days
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg; 1 tab by mouth every 4 hours as needed for pain

14. DME and Supplies:

ostomy supplies, walker, reacher, wound care supplies, cane

15. Safety Measures:

infectious material management, hip precautions, standard precautions, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, transfer with assist, activity supervision

16. Nutrition:

cardiac diet, diabetic

17. Allergies:

angiotensin-converting enzyme inhibitors losartan vasotec

18.A. Functional Limitations

Ambulation, Endurance

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: 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

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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 10/29/2025

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 : 10/22/2025

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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Clinical Condition Requiring Homecare:

The patient is a 70-year-old male, admitted following a right total hip arthroplasty. His past medical history is significant for benign prostatic hyperplasia, gastritis, gastroesophageal reflux disease, mitral valve prolapse, lipoma, diverticulitis of the colon, osteoarthritis, type 2 diabetes mellitus, hypertension, heart murmur, and obesity. The patient has a colostomy for elimination and resides with his brother, who provides assistance with activities of daily living (ADLs) and instrumental ADLs as needed. He is alert and oriented 3 and reports pain at 4/10, currently managed with oxycodone as needed. He denies shortness of breath, and lung auscultation is clear. The right hip surgical site has a non-removable dressing in place, and the patient uses a rolling walker for safe ambulation. Physical therapy evaluation revealed decreased strength in the right lower extremity (3-/5), limited hip flexion, and the need for contact-guard assistance with transfers and short-distance ambulation using a rolling walker. The patient requires verbal cues to equalize step length. Skilled physical therapy services are indicated to improve strength, balance, functional mobility, and safety, with the goal of returning the patient to his prior level of function. The nurse reviewed medications, pain management strategies, and postoperative instructions with the patient, who verbalized understanding.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 10/29/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 10/22/2025
 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 (10/29/25-11/01/25) ,WK2: 1 (11/02/25-11/08/25)

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: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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 Interference with ADLs, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Right Hip - RIGHT HIP DRESSING INTACT

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 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, * how to maintain a diary to monitor effective and non-effective

SN Goals

PATIENT-STATED GOAL: TO MOVE AROUND 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 cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* 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	10/29/2025

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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 (10/29/25-11/01/25) ,WK2: 3 (11/02/25-11/08/25) ,WK3: 2 (11/09/25-11/15/25)

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 , cough/deep breathing exercises, gait training on uneven surfaces, gait training/stair training, transfers training, therapeutic exercises

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 - 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, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance

PT Goals

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

GOALS
Shower/Bathe Self - 03. Partial/moderate assistance

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

Eating - 06. Independent

Car Transfer - 04. Supervision or touching assistance

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

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

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

Toileting Hygiene - 05. Setup or clean-up assistance

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

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	10/29/2025