Home Health Certification and Plan of Care

Order ID: 1150/14037

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
39171415	11/14/2025	From: 11/14/2025 To: 01/12/2026	18879	217058

6. Patient's Name and Address
Cynthia Hargis
225 Altamont Ave,
Catonsville, MD 21228-
443-271-8219

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 02/23/1955 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	11/14/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	11/14/25
I10.	Essential (primary) hypertension	11/14/25
M47.812	Spondylosis w/o myelopathy or radiculopathy cervical region	11/14/25
H90.3	Sensorineural hearing loss bilateral	11/14/25
E11.9	Type 2 diabetes mellitus without complications	11/14/25
E78.5	Hyperlipidemia unspecified	11/14/25
F33.42	Major depressive disorder recurrent in full remission	11/14/25
G47.00	Insomnia unspecified	11/14/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	11/14/25
F41.9	Anxiety disorder unspecified	11/14/25
E04.2	Nontoxic multinodular goiter	11/14/25
R91.1	Solitary pulmonary nodule	11/14/25
K21.9	Gastro-esophageal reflux disease without esophagitis	11/14/25
E66.9	Obesity unspecified	11/14/25
Z68.32	Body mass index [BMI] 32.0-32.9 adult	11/14/25
Z86.0100	Personal history of colonic polyps	11/14/25
Z96.653	Presence of artificial knee joint bilateral	11/14/25
Z87.891	Personal history of nicotine dependence	11/14/25

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 for cholesterol
Tenormin - Atenolol 50 mg 50 mg,Take 1 tablet by mouth once a day blood pressure
Pepcid - Famotidine 20 mg 20 mg, Take 1 tablet by mouth twice a day stomach
Norvasc - Amlodipine Besylate eq 10 mg base 10mg; 1 tab by mouth once a day blood pressure
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg; 1-2 tabs by mouth every 4 hours as needed for pain
Neurontin - Gabapentin 300 mg 300 mg, Take 1 capsule by mouth three times a day pain
Colace - Docusate Sodium 100mg; 1 tab by mouth twice a day bowel regimen
Asa 81 Mg - Aspirin 81 mg; 1 tab by mouth twice a day post hip replacement
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000 IU by mouth once a day SUPPLEMENT
Tylenol - Acetaminophen 500 mg, Take 1 tablet by mouth every 6 hours Take 1 tablet by mouth every 6 hours as needed for pain

14. DME and Supplies:
bath bench, walker, cane

15. Safety Measures:
standard precautions, diabetic precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, ambulates with assistance, transfer with assist, supervision at all times, hip precautions, activity supervision

16. Nutrition:
diabetic

17. Allergies:
lisinopril trazadone hydrochloride

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: Yes

20. Prognosis: good

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

Homebound status: After undergoing Left 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 70-year-old female, status post left total hip replacement with spinal anesthesia on 11/13/2025. Her past medical history is significant for hypertension, vertigo, bilateral high-frequency sensorineural hearing loss, diet-controlled type 2 diabetes mellitus, colon cancer, major depressive disorder, insomnia, back pain, left knee issues, hyperlipidemia, anxiety, and obstructive sleep apnea. She currently requires assistance from her spouse with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The patient is alert and oriented 3, denies pain at the time of visit after taking pain medication, reports no shortness of breath, and demonstrates good appetite. Physical assessment revealed +2 bilateral lower extremity edema, non-removable dressing on the left hip, and the patient ambulating with a rolling walker while wearing TED hose. Skilled nursing reviewed all medications, provided instruction on effective pain management, and reinforced post-operative care, which the patient understood. Physical therapy evaluation indicates the patient is at high risk for falls, as evidenced by a Timed Up and Go (TUG) test of 1:06. The patient participated in review of the home exercise program, including supine therapeutic exercises, sit-to-stand practice, and hourly ambulation, and verbalized understanding of the instructions. Given her current functional limitations, need for mobility assistance, and high fall risk, the patient will benefit from continued skilled therapy services to improve strength, balance, and safe functional mobility.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 11/14/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 10/30/2025
 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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 Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 11/14/2025

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 : 10/30/2025

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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Cynthia Hargis 225 Altamont Ave, Catonsville, MD 21228- 443-271-8219	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

SN WK1: 1 (11/14/25-11/15/25) ,WK2: 1 (11/16/25-11/22/25)

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

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.

LEFT HIP
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, dependent edema, limited endurance, limited range of motion, Pain Interference with ADLs, balance deficit, obesity, #1 - Non-Observable Surgical Wound - Anterior Left Hip - NONREMOVABLE DRESSING NOTED

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: SN/PT TO REMOVE LEFT HIP DRESSING POST OP DAY 7.

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, * 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, * how to promote optimized mobility with strength balance dexterity range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing prevent constipation, 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 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, patient's transportation needs are met, meal preparation is available to patient for all meals

PATIENT-STATED GOAL: TO CONTINUE NOT TO HAVE 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
* how to promote optimized mobility with strength
* balance
* dexterity
* range-of-motion therapeutic exercises
* promotion of peripheral circulation
* fluid and diet intake to promote healing
* prevent constipation
* 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
* 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 keep journal of food and fluid intake
* healthy meal plan tips
* exercise program
* nutritional knowledge
* 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
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

meal preparation is available to patient for all meals

PT Careplans	PT Goals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/14/2025

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PT WK1: 1 (11/14/25-11/15/25) ,WK2: 3 (11/16/25-11/22/25) ,WK3: 2 (11/23/25-11/29/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170G1 - Car Transfer, 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, GG0170I1 - Walk 10 Feet, GG0130B1 - Oral Hygiene, 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: Therapeutic exercise , Dynamic standing balance , Medication Review- Medications reviewed with patient/caregiver., gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: 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 - 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, Medication Review- Patient/caregiver, related purpose and schedule of medications.

PATIENT-STATED GOAL: To walk independently

GOALS

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

Don/Doff Footwear - 06. Independent

Eating - 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

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

Toileting Hygiene - 06. Independent

Sit to Stand - 06. Independent

Medication Review- Patient/caregiver recalls related purpose and schedule of medications.

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/14/2025