Home Health Certification and Plan of Care

Order ID: 1150/14023

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
75267451	11/14/2025	From: 11/14/2025 To: 01/12/2026	595	217058

6. Patient's Name and Address

Delores Battle
8205 Daren Ct,
PIKESVILLE, MD 21208-
410-365-8642

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 08/12/1955 | **9.Sex** Female

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

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	11/14/25
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	11/14/25
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	11/14/25
N18.31	Chronic kidney disease stage 3a	11/14/25
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	11/14/25
E11.36	Type 2 diabetes mellitus with diabetic cataract	11/14/25
I70.0	Atherosclerosis of aorta	11/14/25
K21.9	Gastro-esophageal reflux disease without esophagitis	11/14/25
F39.	Unspecified mood [affective] disorder	11/14/25
E78.00	Pure hypercholesterolemia unspecified	11/14/25
F41.9	Anxiety disorder unspecified	11/14/25
F31.9	Bipolar disorder unspecified	11/14/25
M54.16	Radiculopathy lumbar region	11/14/25
E55.9	Vitamin D deficiency unspecified	11/14/25
E66.9	Obesity unspecified	11/14/25
Z68.30	Body mass index [BMI] 30.0-30.9 adult	11/14/25
Z86.16	Personal history of COVID-19	11/14/25
Z86.0100	Personal history of colonic polyps	11/14/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	11/14/25
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	11/14/25
Z87.891	Personal history of nicotine dependence	11/14/25

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

Norvasc - Amlodipine Besylate eq 10 mg base 1 tablet by mouth once a day
Tylenol - Acetaminophen 500 mg, 2 tablets by mouth every 8 hours
Hyzaar - Hydrochlorothiazide: Losartan Potassium 100-25 mg, 1 tablet by mouth once a day
Metformin - Metformin Hydrochloride 500 MG , Take (500 mg) tablet by mouth before meal
Famotidine - Famotidine 40 mg 1 tablet by mouth once a day
Atorvastatin - Atorvastatin Calcium 40 mg , Take 1 tablet by mouth once a day
Hydromorphone Hydrochloride - Hydromorphone Hydrochloride 2 mg 1 tablet by mouth every 4 hours prn

14. DME and Supplies:

diabetic supplies, walker, commode, , cane, wound care supplies

15. Safety Measures:

walker precautions, fall precautions, diabetic precautions, transfer with assist, sharps precautions, hip precautions, standard precautions

16. Nutrition:

cardiac diet, diabetic

17. Allergies:

HALDOL (HALOPERIDOL) OXYCODONE

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Up As Tolerated, Walker

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: fair

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.

Clinical Condition Requiring Homecare:

The patient is one day post-right total hip replacement performed for end-stage osteoarthritis following significant pain and functional decline despite conservative management. She presents with postoperative pain, limited right hip ROM, mild generalized right lower-extremity weakness, and an antalgic gait pattern. She requires assistance with transfers and household mobility and is at high risk for falls. The patient lives alone in a single-story home with a basement accessible by 13 steps; a friend is currently staying with her to assist with caregiving. Her surgical dressing is clean, dry, and intact, and skilled nursing is scheduled to remove it at seven days postoperatively. Evaluation shows slow, antalgic gait with decreased step length, impaired weight shifting, and reliance on an assistive device. Transfers require verbal cues for sequencing, hand placement, and adherence to hip precautions. Standing balance is decreased, further increasing fall risk. Education was provided on hip precautions, safe mobility, pacing, use of ice, prevention of overuse, and home safety modifications. Home care physical therapy is medically necessary to address impairments in ROM, strength, gait mechanics, transfer safety, stair negotiation, and pain management to support a safe return to functional independence.<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: 10/23/2025
 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 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 : 10/23/2025

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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SN WK1: 2 (11/14/25-11/15/25)

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; 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: M1720 - Anxiety, D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, limited endurance, muscle weakness, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Right Hip - Dsg clean dry and intact

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , 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, * how to take the patient's blood pressure record the reading, 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, * low cholesterol dietary guidelines, 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet exercise monitoring of blood pressure blood sugar home, related medication(s) purpose, schedule remedies, * 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, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * dietary guidelines for managing nutritional deficit, 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

PATIENT-STATED GOAL: regain stregth

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 take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet
* exercise
* monitoring of blood pressure
* blood sugar
* home
* recalls related medication(s) purpose, schedule remedies

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
* low cholesterol dietary guidelines
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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
* dietary guidelines for managing nutritional deficit
* 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
* 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

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	11/14/2025

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PT Careplans

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: 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: HEP: Include ankle pumps, quad sets, glute sets, heel slides, short-arc quads, long-arc quads, and seated/standing knee flexion and extension within tolerance, as appropriate. Instruct on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day., B LE strengthening: Reinforce proper technique, maintain THR precautions during all strengthening activities, monitor for compensatory trunk movements, and adjust exercise intensity based on pain and fatigue levels. Ensure patient uses controlled pacing and avoids excessive hip flexion beyond precautions., Standing balance Training: Provide cues for maintaining upright posture and controlled movement. Ensure surfaces are safe, guard appropriately, and progress challenge only when patient demonstrates good stability., work simplification/energy conservation, gait training on uneven surfaces: Focus gait training on safely negotiating uneven surfaces while maintaining appropriate step length, weight shifting, and hip precautions. Use assistive device as indicated. Provide verbal/tactile cues for upright posture, controlled foot placement, and scanning for hazards. Monitor for instability, increased pain, or compensations. Progress surface challenge only as tolerated., gait training/stair training: Ensure consistent cueing on sequencing, rail use, and controlled pace. Guard closely at the patient's weak side. Progress step height only as safe and tolerated., transfers training: Reinforce slow pacing and correct hand placement. Cue patient to avoid twisting, maintain hip precautions, and ensure full foot contact before standing. Monitor for instability or increased pain.

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 - 06. Independent, 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 - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 _ Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Functional Mobility & Gait, Transfers & ADL Safety

PT Goals

PATIENT-STATED GOAL: To have a successful post op procedure

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Shower/Bathe Self - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 _ Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Functional Mobility & Gait

Transfers & ADL Safety

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

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