Home Health Certification and Plan of Care

Order ID: 1150/15037

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
17128940	12/17/2025	From: 12/17/2025 To: 02/14/2026	19902	217058

6. Patient's Name and Address

Sherman Jones
3405 Liberty Heights Ave,
BALTIMORE, MD 21215-
202-421-8131

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 08/13/1951 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	12/17/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	12/17/25
I10.	Essential (primary) hypertension	12/17/25
M54.16	Radiculopathy lumbar region	12/17/25
E78.5	Hyperlipidemia unspecified	12/17/25
H25.9	Unspecified age-related cataract	12/17/25
N20.0	Calculus of kidney	12/17/25
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	12/17/25
B00.89	Other herpesviral infection	12/17/25
N52.8	Other male erectile dysfunction	12/17/25
R73.03	Prediabetes	12/17/25
Z79.82	Long term (current) use of aspirin	12/17/25
Z86.0100	Personal history of colonic polyps	12/17/25
Z87.891	Personal history of nicotine dependence	12/17/25

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

Aspirin 81Mg - Aspirin 81 mg, Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day with meals DO NOT START TAKING UNTIL AFTER YOUR TOTAL HIP REPLACEMENT SURGERY
Roxicodone - Oxycodone Hydrochloride 5 mg, Take 1 tablet by mouth every 6 hours Take 1 tablet by mouth every 6 hours as needed for pain Do not start taking until after your total hip replacement- this is a post surgical pain medication
Hytrin - Terazosin Hydrochloride 5 mg, Take 1 capsule by mouth twice a day Take 1 capsule by mouth 2 times a day
Mobic - Meloxicam 15 mg, Take 1 table by mouth once a day
Zovirax - Acyclovir Sodium 400 mg, Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day
Cialis - Tadalafil 5 mg , Take 1 tablet by mouth once a day Take 1 tablet by mouth daily at approximately the same time daily without regard to timing of sexual activity
Nifedipine - Nifedipine 60 mg, Take 1 table by mouth once a day
Lipitor - Atorvastatin Calcium 40 mg, , Take 1 table by mouth once a day Take 1 tablet by mouth daily for cholesterol and heart protection
Extra Strength Tylenol - Acetaminophen 500mg (2) by mouth every 6 hours take 1-2 tablets every 6 hours as needed

14. DME and Supplies:

walker

15. Safety Measures:

walker precautions, , bathroom safety, ambulates with device, ambulates with assistance

16. Nutrition:

low sodium, low cholesterol,

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Up As Tolerated

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: 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 Right Hip Joint 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 12/17/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Pamela Cobb
2101 East Jefferson St
Rockville, MD 20852
PHONE: 800-777-7904 FAX: NPI: 1629118948

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 : 11/18/2025

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 74-year-old male status post right total hip arthroplasty performed this week, currently utilizing an assistive device for safety and fall prevention. The operating surgeon is Dr. Cobb (240-632-4375). The patient is alert and oriented to person, place, time, and situation. He reports mild pain rated at 2/10 and denies dizziness, lightheadedness, falls, abnormal bleeding, nausea, or vomiting. He ambulates with a rolling walker for safety and fall prevention and requires contact guard assistance for transfers and short-distance ambulation. Prior to surgery, the patient was independently ambulatory without an assistive device, though he occasionally used a single-point cane. Current <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> reveals decreased strength in the right lower extremity with manual muscle testing graded at approximately 2-/5 secondary to postoperative hip pain, resulting in limited mobility and endurance. Lung sounds are clear to auscultation bilaterally. The patient reports his last bowel movement occurred yesterday and denies pain or difficulty with urination. Appetite is described as slow but adequate. He lives alone and reports relocating from California via Washington, D.C. Surgical dressing is intact with no signs of abnormal drainage or bleeding, and no other wounds are noted. The patient was instructed to keep the dressing clean and dry and to avoid soaking or getting it wet. Education was provided regarding signs and symptoms of infection and complications, including the need to contact the surgeon immediately if there is increased bruising, pain, swelling, or other concerning changes. Dressing removal, incision <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, measurement, and photographic documentation are planned for the next nursing visit. All medications were reviewed with the patient, including pain management strategies utilizing prescribed anti-inflammatory medications. The patient demonstrated understanding of medication purposes and dosing. Instruction was also provided on the use of ice therapy as directed for pain and swelling control, hydration to prevent dehydration, and the importance of incentive spirometer use to promote pulmonary function. Discharge instructions were reviewed in full, and informed consent was explained and signed by the patient, indicating understanding. The patient stated he will contact the surgeon to schedule his follow-up appointment. A physical therapy evaluation was completed, during which hip precautions were reviewed and verbalized as understood by the patient. The patient was instructed in an initial home exercise program consisting of seated therapeutic exercises aimed at reducing stiffness and improving strength and range of motion in the right hip. The patient would benefit from continued skilled physical therapy services to address deficits in strength, range of motion, balance, and functional mobility, with the goal of improving safety and facilitating a return to prior level of function.
 Date of Order 12/17/2025 Orders Physician Face-to-Face Date: 11/18/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Hip Joint 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
 1 - SOC - SN Notes: soc PT Eval Notes: eval
 Physician Cobb, Pamela

SN Careplans

SN WK1: 2 (12/17/25-12/20/25)

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: 0. No assistance needed - patient is independent or does not have needs in this area

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.

s/p left hip joint replacement dressing remove 7-day post-surgery dressing removed measure incision and photograph; 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

SN Goals

PATIENT-STATED GOAL: to walk without walker

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
* 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
* 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
* how to incorporate lifestyle modifications to optimize genito-urinary condition including diet
* exercise
* home remedies
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* causes of erectile dysfunction
* self-care
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/17/2025

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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
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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.

s/p left hip joint replacement dressing remove 7-day post-surgery dressing removed measure incision and photograph; 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.
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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
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Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

keep dressing clean and dry s/p left hip joint replacement dressing remove 7-day post-surgery dressing removed measure incision and photograph
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, abnormal blood pressure, urine retention, limited endurance, limited range of motion, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, bruising/discoloration, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Hip -

PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: keep dressing clean and dry. No soaking or wetting dressing. Dressing to be removed in 7 days post-surgery, incision will be assessed measured and photographed, monitor intake & output, coordinate/arrange preparation of missing meals

TEACH PATIENT/CAREGIVER: * 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, * 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 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * causes of erectile dysfunction self-care, related medication(s) purpose, schedule, * how to incorporate lifestyle modifications to optimize genito-urinary condition including diet exercise home remedies, 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

meal preparation is available to patient for all meals

PT Careplans	PT Goals

Signature of Physician:	Date
	PAGE 3 of 4
Optional Name/Signature of Nurse/Therapist:	Date
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PT WK1: 2 (12/17/25-12/20/25) ,WK2: 2 (12/21/25-12/27/25) ,WK3: 2 (12/28/25-01/03/26)

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, equipment training, 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, 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, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Medication Review

PATIENT-STATED GOAL: To be able to walk without a walker

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

Shower/Bathe Self - 03. Partial/moderate assistance

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

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

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

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

Picking Up Object - 04. Supervision or touching assistance

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

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

Eating - 06. Independent

Medication Review

Signature of Physician:	Date
	PAGE 4 of 4
Optional Name/Signature of Nurse/Therapist:	Date
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