Home Health Certification and Plan of Care

Order ID: 1150/15023

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
19314892	12/17/2025	From: 12/17/2025 To: 02/14/2026	19903	217058

6. Patient's Name and Address

Michael Dambrosio
20 Cascade Rd,
ARNOLD, MD 21012-
410-530-3070

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 08/15/1959 **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
J45.909	Unspecified asthma uncomplicated	12/17/25
E66.9	Obesity unspecified	12/17/25
Z68.36	Body mass index [BMI] 36.0-36.9 adult	12/17/25
Z79.01	Long term (current) use of anticoagulants	12/17/25
Z86.711	Personal history of pulmonary embolism	12/17/25
Z86.718	Personal history of other venous thrombosis and embolism	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

Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg; 1 tab by mouth every 4 hours as needed for pain
Proair - Proair 90 mcg/actuation , Inhale 1 to 2 puffs inhalant every 4 hours Inhale 1 to 2 puffs by mouth every 4 hours as needed for cough, shortness of breath or wheezing (Rescue inhaler)
BREYNA (BUDESONIDE/FORMOTEROL) 160/4.5UG; 2 PUFFS inhalant twice a day COPD
Colace - Docusate Sodium 100MG; 2 TABS by mouth once a day BOWEL REGIMEN
Cephalexin - Cephalexin eq 500 mg base 500MG; 1 CAP by mouth every 8 hours POST OP HIP REPLACEMENT
Drisdol - Ergocalciferol 1,250 mcg (50,000 unit), Take 1 capsule by mouth once a week Take 1 capsule by mouth every 7 days
Depakote Er - Divalproex Sodium 500 mg 500 mg, Take 3 tablets by mouth at bedtime Take 3 tablets by mouth daily at bedtime - Covering for Dr Davis
Cozaar - Losartan Potassium 50 mg , Take 1 tablet by mouth in the morning BLOOD PRESSURE
Crestor - Rosuvastatin Calcium 10 mg 10 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily to prevent heart attack and stroke
Pradaxa - Dabigatran Etexilate Mesylate 150 mg 150 mg , Take 1 capsule by mouth twice a day BLOOD THINNER
Tylenol Arthritis - Acetaminophen 650 mg, Take 650 mg Tablet by mouth every 6 hours Take 650 mg by mouth every 6 hours as needed for pain
Budesonide - Budesonide 160-4.5 mcg/actuation Inhl HFAA, INHALE 2 PUFFS inhalant twice a day INHALE 2 PUFFS BY MOUTH 2 TIMES A DAY (THIS REPLACES SYMBICORT)
Lantus Solostar - Insulin Glargine Recombinant 5 UNITS subcutaneous in the evening IF FS > 250

14. DME and Supplies:

walker

15. Safety Measures:

standard precautions, ambulates with device, fall precautions, bleeding precautions, walker precautions, medication safety, ambulates with assistance, hip precautions, anticoagulant precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

shellfish codeine

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Up As Tolerated, Walker, Exercises Prescribed

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

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 : 12/05/2025

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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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 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 a 66-year-old male status post right total hip replacement via anterior approach on 12/15/25, with a past medical history significant for pulmonary embolism, deep vein thrombosis, hypertension, and asthma. He is alert and oriented 3, reports pain at 8/10 with improvement after oxycodone taken at 5 a.m., denies shortness of breath, reports good appetite, and last bowel movement prior to surgery. The right hip dressing is intact with no drainage noted, and the patient is ambulating with a walker for safety. Skilled nursing reviewed medications and pain management with demonstrated understanding. Physical therapy evaluation revealed decreased endurance, strength, balance, and functional mobility, unsteady gait, difficulty with transfers and stair negotiation, and increased fall risk, requiring assistance and an assistive device for safe mobility outside the home. The patient received education on edema management, incision infection signs and symptoms, anterior hip precautions, home safety and fall prevention, safe transfers, bed mobility, ambulation with a walker, therapeutic exercises, icing protocol, and the importance of daily ambulation; he required minimal assistance to standby assistance for transfers, bed mobility, and ambulation. Pain is currently well controlled with medications, and the patient verbalized understanding of medication use and safety precautions. The patient will benefit from continued home physical therapy to improve strength, mobility, balance, and safety to prevent falls and restore independence, with a plan of care agreed upon and transition to outpatient physical therapy beginning 12/31/25, and follow-up with PA Hans on 12/30/25.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 12/17/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 12/05/2025
 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 (12/17/25-12/20/25) ,WK2: 1 (12/21/25-12/27/25)

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; 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: D0160 - Depression, M2020 - Oral Med Management, Home Safety, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited range of motion, swelling of

SN Goals

PATIENT-STATED GOAL: I WANT MY PAIN TO GET 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 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
* lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* 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/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

Signature of Physician:

Date

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

Date
12/17/2025

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affected area, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Right Hip - RIGHT HIP DRESSING INTACT NO DRAINAGE NOTED

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver.. , cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, physician-ordered wound care: SN/PT TO REMOVE RIGHT HIP DRESSING POST OP DAY 7. KEEP OPEN TO AIR, coordinate/arrange for maintenance of clean/uncluttered living area

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, * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, 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, * 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, patient's living environment is clean/uncluttered, meal preparation is available to patient for all meals

patient's living environment is clean/uncluttered

meal preparation is available to patient for all meals

PT Careplans

PT WK1: 2 (12/17/25-12/20/25) ,WK2: 3 (12/21/25-12/27/25) ,WK3: 1 (12/28/25-01/03/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 Dyspnea, Pain Effect on Sleep, 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, 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, GG0130B1 - Oral Hygiene

PROCEDURES: incentive spirometer, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide Seated-LAQ, pillow squeeze Standing-Mini squat, heel/toe raise, hip flex, leg curls., therapeutic modalities: Apply heat/ice to R hip x 20 minutes with necessary barrier and skin assessments q 5 minutes., gait training on uneven surfaces, gait training/stair training, transfers training, assist with infection control, assist with fall prevention

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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 06. Independent, 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 - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

PT Goals

PATIENT-STATED GOAL: To be able to independently get up and down the steps

GOALS
Chair to Bed to Chair - 06. Independent

Shower/Bathe Self - 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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 05. Setup or clean-up assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

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

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/17/2025