Home Health Certification and Plan of Care

Order ID: 1150/15405

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
981098311	01/13/2026	From: 01/13/2026 To: 03/13/2026	20736	217058

6. Patient's Name and Address
Antoinette Grant
3049 Wadsworth Ct Unit B,
fort Meade, MD 20755-
703-595-1126

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 12/01/1970 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	01/13/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	01/13/26
M17.12	Unilateral primary osteoarthritis left knee	01/13/26
M54.12	Radiculopathy cervical region	01/13/26
E78.00	Pure hypercholesterolemia unspecified	01/13/26
N62.	Hypertrophy of breast	01/13/26
R91.1	Solitary pulmonary nodule	01/13/26
E66.9	Obesity unspecified	01/13/26
Z68.38	Body mass index [BMI] 38.0-38.9 adult	01/13/26
Z87.891	Personal history of nicotine dependence	01/13/26

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

Colace - Docusate Sodium 100mg; 1 cap by mouth twice a day stool softner
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg; 1 tab by mouth every 4 hours as needed for pain
Asa 81 Mg - Aspirin 81mg; 1 tab by mouth twice a day post hip replacement

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

15. Safety Measures:
ambulates with device, walker precautions, , ambulates with assistance, transfer with assist, hip precautions, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
vancomycin

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: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

22.B.Discharge Plans
patient will be responsible for managing treatment

Homebound status: After undergoing Right Total Hip Replacement, 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 55-year-old female status post right total hip replacement (anterior approach) performed on 01/12/26 under spinal anesthesia, who returned home the same day with continuous family support. Past medical history is significant for obesity, osteoarthritis of the right hip, and hypercholesterolemia. Skilled nursing services are ordered at a frequency of 1 visit per week for 2 weeks, and a physical therapy evaluation was completed. Family members are assisting with all ADLs and IADLs. At the time of assessment, the patient was alert and oriented 3, reporting right hip pain rated 4/10, with last dose of oxycodone and acetaminophen taken at 7:25 AM, resulting in effective pain control. The patient denied shortness of breath; lung sounds were clear throughout, appetite was reported as good, and last bowel movement occurred prior to the visit. The right hip incision was intact, and the patient was observed wearing TED stockings and ambulating with a rolling walker for safety. Skilled nursing reviewed all medications with the patient, including dosage, frequency, and pertinent side effects, and provided education on postoperative care and effective pain management; the patient verbalized understanding. Physical therapy evaluation identified postoperative impairments including hip pain, decreased strength, reduced endurance, impaired balance, unsteady gait, difficulty with transfers and bed mobility, decreased safety awareness, difficulty negotiating steps, history of falls, and increased risk for future falls. The patient requires assistance from another person and an assistive device to safely ambulate and leave the home. Transfer training was provided with emphasis on safe sit-to-stand technique using the walker, including proper hand and foot placement, forward weight shift, and reaching back prior to sitting; the patient required minimal assistance to standby assist. Bed mobility training was completed with cueing for proper body mechanics; the patient required minimal assistance for all bed mobility tasks. Gait training on level surfaces was initiated using a rolling walker, with the patient requiring standby assist and verbal cues for proper positioning within the walker, increased right step height and length, and overall safety; the patient was instructed to use the walker at all times. Therapeutic exercise instruction included supine exercises consisting of ankle pumps, quadriceps sets, and gluteal sets (120 repetitions), as well as heel slides (110 repetitions). Passive range of motion of the right hip was performed in the supine position. A written home exercise program (HEP) was left in the home with instructions to complete exercises twice daily. Education was provided regarding edema management, including the causes of postoperative swelling, elevation of lower extremities above heart level during rest, and use of compression garments if recommended by the physician. The patient was instructed on signs and symptoms of infection such as fever, chills, redness, swelling, increasing pain, bleeding, drainage from the incision, persistent nausea/vomiting, or pain not relieved by medication, and verbalized understanding. Additional education from the patient handbook included home safety, fall prevention strategies, fall risk factors, and environmental modifications to reduce fall risk. The patient was also educated on the importance of daily ambulation to promote circulation and prevent complications related to immobility, with instructions to begin short walks every 1-2 hours within the home and to gradually progress to 3-5 minute walks as tolerated. Pain management education included taking medications at the onset of pain, awareness of potential side effects such as dizziness and constipation, use of ice to the right hip for 20 minutes with a barrier and skin checks every 5 minutes, and the recommendation to take pain medication one hour prior to physical therapy sessions. Emergency precautions were reviewed, including when to call 911 or the provider for chest pain, shortness of breath, or unrelieved pain. The physical therapy plan of care was discussed and developed with the patient and caregiver, with mutual agreement. The patient will receive home physical therapy beginning 01/13/26 at a frequency of 3 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> per week for 2 weeks, transition to outpatient physical therapy on 01/26/26, and follow up with PA Mena on 01/28/26 to support continued recovery, improve functional mobility and safety, and restore independence within the home.
 Date of Order 01/13/2026 Orders Physician Face-to-Face Date:

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/13/2026

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 : 12/31/2025

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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12/31/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Hip Replacement 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 Huang , James

SN Careplans

SN WK1: 1 (01/13/26-01/17/26) ,WK2: 1 (01/18/26-01/24/26)

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: 10. None of the above

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, M1400 - Dyspnea, limited range of motion, limited endurance, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Right Hip - nonremovable dressing intact no drainage noted

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Hip - nonremovable dressing intact no drainage noted, 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: SN REMOVE RIGHT HIP DRESSING POST OP DAY 7. KEEP INCISION OPEN TO AIR

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 medicatio, * 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 relaxatio, * 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 manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, related medic, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: TO WALK WITHOUT 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 manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* recalls related medic

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 relaxatio

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 medicatio

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

01/13/2026

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PT WK1: 3 (01/13/26-01/17/26) ,WK2: 3 (01/18/26-01/24/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs

PROCEDURES: 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 ice to R hip x 20 minutes with necessary barrier and skin assessments q 5 minutes.

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 relaxatio

PATIENT-STATED GOAL: To return to independence.

GOALS
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 relaxatio

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/13/2026