

Home Health Certification and Plan of Care				Order ID: 1150/15493	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
561038799		01/17/2026		From: 01/17/2026 To: 03/17/2026	
				4. Medical Record No.	
				20913	
				5. Provider No.	
				217058	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Jennie Williams				HomeCentris Healthcare LLC	
827 Wedgewood Rd,				10 Crossroads Drive, Suite 102	
BALTIMORE, MD 21229-				Owings Mills, MD 21117-8284	
443-301-3630				410-321-8448	
				1487113239	
8. DOB				9.Sex	
04/08/1961				Female	
11. ICD		Principal Diagnosis		Date	
Z47.1		Aftercare following joint replacement surgery		01/17/26	
13. ICD		Other Pertinent Diagnoses		Date	
Z96.642		Presence of left artificial hip joint		01/17/26	
G56.03		Carpal tunnel syndrome bilateral upper limbs		01/17/26	
J30.9		Allergic rhinitis unspecified		01/17/26	
D64.9		Anemia unspecified		01/17/26	
R56.9		Unspecified convulsions		01/17/26	
14. DME and Supplies:				15. Safety Measures:	
commode, walker, cane				infectious material management, standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, transfer with assist, hip precautions	
16. Nutrition:				17. Allergies:	
Z. NO PHYSICIAN-ORDERED DIET				no known allergies	
18.A. Functional Limitations				18.B. Activities Permitted	
Endurance, Ambulation				Walker, Cane, Up As Tolerated, 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:				22.B.Discharge Plans	
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.				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: <p class="MsoNoSpacing">The patient is a 64-year-old female status post left hip replacement, with a past medical history of left hip osteoarthritis, prediabetes, seizure disorder, and a brain meningioma status post craniotomy in 2019. She is alert and oriented 3 and reports left thigh pain rated 5/10. She denies shortness of breath, has clear lung sounds, reports good appetite, and had a bowel movement prior to surgery; she is taking Colace and Senna. The surgical site dressing is clean, dry, and intact, and the patient is wearing TED stockings and using a walker for safe ambulation. Skilled nursing reviewed all medications, dosages, frequency, and pertinent side effects, and provided education on pain management and post-operative instructions, which the patient verbalized understanding. PT evaluation revealed that the patient ambulates 30 feet indoors with a rolling walker and verbal cues to maintain proper gait and leg positioning, performs 14 steps with a cane and supervision, requires moderate assistance for bed mobility of the left leg, and requires supervision for transfers from bed, sofa, or bedside commode. The patient lives with her husband in a row house with four steps to enter, with bed and bathroom on the second floor, and is considered homebound due to the effort required to leave the home. She tolerated 10 repetitions of supine quadriceps sets, gluteal sets, bridging, hip flexion, knee extension, and ankle pumps. She was instructed to take Tylenol three times daily and oxycodone as directed, use ice for 20 minutes several times per day, and elevate the left leg above heart level to reduce swelling. The patient would benefit from continued home therapy to improve strength, functional mobility, transfers, balance, and return to independence.</o:p></p> <p class="MsoNoSpacing"><o:p> </o:p></p> <p class="MsoNoSpacing">Date of Order<o:p></o:p></p> <p class="MsoNoSpacing">01/17/2026 Order<o:p></o:p></p> <p class="MsoNoSpacing">Physician Face-to-Face Date: 12/31/2025 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></p> <p class="MsoNoSpacing"> 1 - SOC - SN Notes:<o:p></o:p></p> <p class="MsoNoSpacing">PT Eval Notes:<o:p></o:p></p> <p class="MsoNoSpacing">Physician: Huang, James</p>					
SN Careplans				SN Goals	
SN WK1: 2 (01/17/26-01/17/26)				PATIENT-STATED GOAL: TO WALK WITHOUT PAIN	
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				GOALS	
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance				patient/caregiver recalls	
HOSPITALIZATION RISKS: 10. None of the above				* how to achieve wound healing including cleaning and dressing wound	
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				* 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 medicatio	
				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,	
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 01/17/2026					
24. Physician's Name and Address				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.	
James Huang				F2F date : 12/31/2025	
8028 Ritchie Hwy					
Pasadena, MD 21122					
PHONE: 410-737-5600 FAX: 14107375391 NPI: 1154567709					
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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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: M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, limited range of motion, limited strength, limited endurance, Pain Interference with ADLs, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Left Hip - LEFT HIP DRESSING INTACT NO DRAINAGE NOTED PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Hip - LEFT HIP DRESSING INTACT NO DRAINAGE NOTED, Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: SN TO REMOVE LEFT HIP DRESSING POST OP DAY 7. KEEP 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals	treatments, and what works best to relieve pain * teach relaxatio patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule meal preparation is available to patient for all meals
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PT Careplans PT WK1: 3 (01/17/26-01/17/26) ,WK2: 3 (01/18/26-01/24/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, 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, GG0130B1 - Oral Hygiene, #2 - Observable Surgical Wound - Anterior Left Thigh - PROCEDURES: physician-ordered wound care: #2 - Observable Surgical Wound - Anterior Left Thigh -, Home exercise program : Supine hip flexion, quad sets, glut sets, bridging, Standing knee flexion, hip abduction, plantarflexion, squats. Sitting knee extension, ankle pumps , physician-ordered wound care, wound vacuum, equipment training, gait training on uneven surfaces, gait training/stair training, transfers training 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 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, Car Transfer - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Upper Body Dressing - 06. Independent	PT Goals PATIENT-STATED GOAL: Be able to walk without pain using my cane GOALS Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance 1 - Step (curb) - 05. Setup or clean-up assistance 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 Picking Up Object - 05. Setup or clean-up assistance Car Transfer - 06. Independent Shower/Bathe Self - 04. Supervision or touching assistance Chair to Bed to Chair - 05. Setup or clean-up assistance Toilet Transfer - 05. Setup or clean-up assistance Lower Body Dressing - 03. Partial/moderate assistance Don/Doff Footwear - 03. Partial/moderate assistance 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 relaxatin
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/17/2026

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			Sit to Stand - 05. Setup or clean-up assistance 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 Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Upper Body Dressing - 06. Independent	

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