# Home Health Certification and Plan of Care

**Order ID: 1150/16486**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 57310410 | 02/21/2026 | From: 02/21/2026 To: 04/21/2026 | 22206 | 217058 |

**6. Patient's Name and Address**

Diana Morris
218 Armstrong Ln,
PASADENA, MD 21122-
443-866-7946

**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** 01/11/1963 | **9.Sex** Female

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| Z47.1 | Aftercare following joint replacement surgery | 02/21/26 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| Z96.642 | Presence of left artificial hip joint | 02/21/26 |
| B02.29 | Other postherpetic nervous system involvement | 02/21/26 |
| H90.3 | Sensorineural hearing loss bilateral | 02/21/26 |
| I48.91 | Unspecified atrial fibrillation | 02/21/26 |
| D68.69 | Other thrombophilia | 02/21/26 |
| I70.0 | Atherosclerosis of aorta | 02/21/26 |
| K76.0 | Fatty (change of) liver not elsewhere classified | 02/21/26 |
| M54.50 | Low back pain unspecified | 02/21/26 |
| G89.29 | Other chronic pain | 02/21/26 |
| M35.3 | Polymyalgia rheumatica | 02/21/26 |
| E78.00 | Pure hypercholesterolemia unspecified | 02/21/26 |
| K21.9 | Gastro-esophageal reflux disease without esophagitis | 02/21/26 |
| F33.9 | Major depressive disorder recurrent unspecified | 02/21/26 |
| J44.9 | Chronic obstructive pulmonary disease unspecified | 02/21/26 |
| G47.33 | Obstructive sleep apnea (adult) (pediatric) | 02/21/26 |
| R73.03 | Prediabetes | 02/21/26 |
| Z87.891 | Personal history of nicotine dependence | 02/21/26 |

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

Ducolax - Bisacodyl 5mg by mouth once a day For constipation
Mobic - Meloxicam 15 mg / 1 tablet by mouth once a day
CYMBALTA 30 mg CPDR SR / 1 capsule by mouth twice a day for depression and chronic pain.
Protonix - Pantoprazole Sodium 40 mg / 1 tablet by mouth in the morning take 30 to 60 minutes before breakfast for acid blocker
Xalatan - Latanoprost 0.005 perc 0.005 perc Instill 1 drop left eye in the evening
Zetia - Ezetimibe 10 mg / 1 tablet by mouth once a day
CARDIZEM 120 mg 24hr SR / 1 capsule by mouth once a day
PRAVACHOL 20 mg / 1 tablet by mouth in the evening for high cholesterol and heart protection
Temovate - Clobetasol Propionate 0.05 percent topical ointment topical at bedtime Apply to affected area(s)
Spiriva Respimat - Tiotropium Bromide 0 2.5 mcg/actuation by mouth once a day Inhale 2 puffs by mouth (controller inhaler)
Biotin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tablet by mouth once a day
Omega 3 Fish Oil - Cod Liver Oil 1 capsule by mouth once a day
Multivitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tablet by mouth once a day
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 capsule by mouth once a day
Oxycontin - Oxycodone Hydrochloride 5 mg by mouth every 4 hours Take as needed for pain

**14. DME and Supplies:**

rolling walker, , , cane

**15. Safety Measures:**

walker precautions, transfer with assist, , hip precautions, , ambulates with device, ambulates with assistance, activity supervision

**16. Nutrition:**

Z. NO PHYSICIAN-ORDERED DIET

**17. Allergies:**

tree nuts, such as cashews or walnuts atorvastatin crestor

**18.A. Functional Limitations**

Ambulation

**18.B. Activities Permitted**

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: Yes

**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 Left 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 63-year-old female with a past medical history significant for osteoarthritis of the left hip, status post left total hip replacement performed on 02/19/2026. She returned home the same day with assistance from family and currently has support from her fianc and a friend, Gary, who assists with care as needed. On assessment, the patient was alert and oriented to person, place, and time, resting comfortably on the couch at the time of the visit, with her fianc present. She denied chest pain or discomfort. She reported surgical site pain rated 5/10 and stated that although she is taking her prescribed pain medication as directed, she feels it has been less effective than expected and expressed concern about having an adequate supply in the event of an anticipated snowstorm. The patient contacted her surgeon during the nursing visit to discuss these concerns. An ice pack was in place over the surgical site and is being used appropriately as instructed. The non-removable surgical dressing was observed to be clean, dry, and intact, with planned removal scheduled for 02/28/2026. No signs or symptoms of infection were noted. The patient was educated on monitoring for infection, including fever, chills, redness, swelling, increased pain, bleeding, drainage from the incision, persistent nausea or vomiting, or pain unrelieved by medication, and verbalized understanding. She reported no bowel movement since the day of surgery and is currently on a bowel regimen. Education was provided regarding the use of stool softeners, hydration, and the importance of contacting her primary care provider if no bowel movement occurs within three days. No bilateral lower extremity swelling was observed, and thromboembolism-deterrent (TED) stockings were in place as prescribed. Medications were reviewed with no discrepancies, missing medications, or refill needs identified. Admission paperwork was completed and signed, and the patient agreed with the established plan of care. She is scheduled for follow-up with the surgeon on 03/06/2026 and will begin outpatient physical therapy on 03/09/2026. Physical therapy evaluation was completed. Following joint replacement, the patient demonstrates decreased endurance and mobility, placing her at increased risk for falls. She currently requires the assistance of another person and an assistive device to safely leave the home. Identified deficits include left hip pain, decreased hip strength, reduced functional mobility, difficulty negotiating stairs, unsteady gait, impaired balance, difficulty with transfers and bed mobility, decreased safety awareness, and overall increased fall risk. She requires minimal assistance to standby assistance for transfers with a walker, with cueing provided for proper hand and foot placement, forward weight shift, and reaching back prior

**23. Signature and Date of Verbal SOC Where Applicable:**

Electronically Signed by Messick, Charles RN on 02/21/2026

**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 : 02/10/2026

**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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to sitting. Bed mobility also requires minimal assistance with verbal cues to improve body mechanics and promote independence. Gait training was performed on level surfaces using a walker; the patient required standby assistance with cueing for proper positioning within the walker, improved bilateral step height and length, and overall safety. She was instructed to use the walker at all times during ambulation. Passive range of motion of the left hip was performed in the supine position. The patient was instructed in and completed supine therapeutic exercises including ankle pumps, quadriceps sets, and gluteal sets (1 set of 20 repetitions each), and heel slides (1 set of 10 repetitions). A written home exercise program was left in the home with instructions to perform exercises twice daily. Education was provided on the importance of daily ambulation to promote circulation and prevent complications of immobility, with instructions to initiate short walks within the home every 1-2 hours and to begin with 3-5-minute longer walks, progressing gradually as tolerated. The patient was also instructed to apply ice to the left hip for 20 minutes at a time, using a protective barrier and performing skin checks every five minutes. Hip precautions were reviewed per discharge instructions: weight-bearing as tolerated with walker; hip flexion greater than 90 degrees permitted; avoidance of combined hip flexion with external rotation; and avoidance of combined hip extension with external rotation. Education was provided regarding edema management, including elevating the lower extremities above heart level during rest periods and use of compression garments if recommended by the physician. Fall prevention strategies and home safety measures were reviewed in detail, including risk factors for falls and environmental modifications to reduce hazards. Pain management education included taking pain medication at the onset of pain, premedicating approximately one hour prior to physical therapy sessions, and monitoring for side effects such as dizziness and constipation. The patient was instructed to seek emergency care or notify her provider for chest pain, shortness of breath, or unrelieved pain. The patient verbalized understanding of all education provided. The patient will receive skilled home physical therapy services three times weekly for two weeks beginning 02/23/2026 to address strength, balance, mobility, transfers, gait training, stair negotiation, and safety awareness in order to restore independent function in the home and reduce fall risk. Without skilled therapy, she remains at risk for falls, further functional decline, and loss of independence. The plan of care was discussed with the patient and caregiver, and both are in agreement. Continued monitoring of pain control, bowel status, wound healing, functional mobility, and overall safety will be maintained. <br> Date of Order 02/21/2026 Orders Physician Face-to-Face Date: 02/10/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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 <br> 1 - SOC - SN Notes: soc PT Eval Notes: eval <br> Physician Huang , James

## SN Careplans

SN WK1: 1 (02/21/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26)

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: 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: D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: 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

## SN Goals

PATIENT-STATED GOAL: to walk without pain

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 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
* 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

meal preparation is available to patient for all meals

| Signature of Physician: | Date |
|---|---|
| | |



| Optional Name/Signature of Nurse/Therapist: | Date |
|---|---|
| Electronically Signed by Messick, Charles RN | 02/21/2026 |

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and covering with dry gauze daily and as needed.

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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

## PT Careplans

PT WK2: 3 (02/22/26-02/28/26) ,WK3: 3 (03/01/26-03/07/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea, Pain Interference with Therapy activities, 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: 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. hip abd, therapeutic modalities: Apply ice to L hip x 20 minutes with necessary barrier and skin assessments q 5 minutes., gait training/stair training, transfers training

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 - 06. Independent, 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

## PT Goals

PATIENT-STATED GOAL: To be able to walk with no pain

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 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

| Signature of Physician: | Date |
|---|---|
| | PAGE 3 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 02/21/2026 |