Home Health Certification and Plan of Care

Order ID: 1150/16552

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
8WF7AU8RY62	02/25/2026	From: 02/25/2026 To: 04/25/2026	8199	217058

6. Patient's Name and Address

Leroy Gladden
3428 Saint Ambrose Ave,
Baltimore, MD 21215-
410-306-5631

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 07/11/1946 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	02/25/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	02/25/26
I10.	Essential (primary) hypertension	02/25/26
E11.69	Type 2 diabetes mellitus with other specified complication	02/25/26
E78.00	Pure hypercholesterolemia unspecified	02/25/26
I70.0	Atherosclerosis of aorta	02/25/26
J44.9	Chronic obstructive pulmonary disease unspecified	02/25/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	02/25/26
I45.10	Unspecified right bundle-branch block	02/25/26
I44.5	Left posterior fascicular block	02/25/26
I69.341	Monoplg low lmb fol cerebral infrc aff right dominant side	02/25/26
I69.328	Oth speech/lang deficits following cerebral infarction	02/25/26
I69.392	Facial weakness following cerebral infarction	02/25/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	02/25/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	02/25/26
R91.1	Solitary pulmonary nodule	02/25/26
Z86.0100	Personal history of colonic polyps	02/25/26
Z87.891	Personal history of nicotine dependence	02/25/26

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

Aspirin 81mg by mouth twice a day
Lipitor - Atorvastatin Calcium eq 80 mg base 0 80 mg, Take 1 tablet by mouth once a day CHOLESTEROL
Advair Diskus 250/50 - Fluticasone Propionate: Salmeterol Xinafoate 0.25 mg/inh;eq 0.05 mg base/inh 2 PUFFS inhalant once a day COPD
Hydrochlorothiazide - Hydrochlorothiazide 25 mg 25MG; 1 TAB by mouth once a day BLOOD PRESSURE
Lantus - Insulin Glargine Recombinant 100 units/ml 6 UNITS subcutaneous at bedtime DM
Imdur - Isosorbide Mononitrate 30 mg 0 30 mg , Take 30 mg by mouth once a day BLOOD PRESSURE
Jardiance - Empagliflozin 12.5 MG; 1 TAB by mouth once a day DM
Cozaar - Losartan Potassium 100 mg 50 mg 25 mg, Take 25 mg by mouth once a day BLOOD PRESSURE
Metoprolol Tartrate - Metoprolol Tartrate 25 mg 25MG; 1 TAB by mouth twice a day BLOOD PRESSURE
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg 0.4MG; 1 TAB by mouth once a day PROSTATE
Brilinta - Ticagrelor 90 mg, Take 90 mg by mouth twice a day
Proair - Proair 90 mcg, Inhale 2 puffs inhalant every 6 hours AS NEEDED FOR SOB/WHEEZING
Tylenol - Acetaminophen 650 mg 650 mg 650 mg, Take 1 tablet by mouth every 6 hours for pain

14. DME and Supplies:

walker, bath bench, cane

15. Safety Measures:

diabetic precautions, ambulates with device, walker precautions, , ambulates with assistance, transfer with assist, supervision at all times, hip precautions, , activity supervision

16. Nutrition:

diabetic, cardiac diet,

17. Allergies:

pcn shellfish

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: 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 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 73-year-old male status post left total hip arthroplasty (anterior approach) performed yesterday. Past medical history is significant for coronary artery disease, benign prostatic hyperplasia, obstructive sleep apnea, type 2 diabetes mellitus, chronic obstructive pulmonary disease, and a history of smoking. Skilled nursing services are ordered at a frequency of 1 visit per week for 2 weeks, and a physical therapy evaluation was completed. The patient's family (son and spouse) is available and assists with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed during the immediate postoperative period. On skilled nursing assessment, the patient was alert and oriented to person, place, and time. He reported left hip pain rated 6/10 and stated he last took prescribed pain medication approximately 4 hours prior to the visit. He denied shortness of breath and reported a good appetite. He stated his last bowel movement occurred prior to surgery, placing him at risk for postoperative constipation. The left hip surgical incision on the anterior aspect was observed to be clean and dry with no noted drainage. The patient is utilizing a walker for safe ambulation. Medication reconciliation was completed, and skilled nursing reviewed postoperative instructions and the medication regimen with the patient, son, and spouse; all verbalized understanding. The plan of care includes continued skilled nursing follow-up for postoperative monitoring, pain management reinforcement, incision surveillance, bowel regimen/constipation prevention education, and ongoing assessment for cardiopulmonary concerns given his CAD and COPD history. Physical therapy will provide skilled intervention to address postoperative functional decline, restore mobility, and reduce fall risk. During PT evaluation, the patient's prior level of function included independent ambulation without an assistive device, with occasional use of a single-point cane. Currently, he demonstrates decreased left lower extremity strength (2-/5 manual muscle testing) related to pain and stiffness. He requires contact guard assistance for transfers and short-distance ambulation with a rolling walker and is able to negotiate steps using two handrails. The patient was instructed in an initial home exercise program consisting of seated therapeutic exercises with emphasis on gentle stretching into hip flexion and extension. Ongoing skilled PT is recommended to improve strength, balance, gait safety, and functional mobility in order to facilitate return to prior level of function.
 Date of Order 02/25/2026 Orders Physician Face-to-Face Date: 01/28/2026 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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/25/2026

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 : 01/28/2026

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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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 (02/25/26-02/28/26) ,WK2: 1 (03/01/26-03/07/26)

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; 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.

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 Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Left Hip - DRESSING INTACT

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Hip - DRESSING INTACT: REMOVE LEFT HIP DRESSING POST OP DAY 7, cough/deep breathing exercises, incentive spirometer, home exercise program

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, * 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

SN Goals

PATIENT-STATED GOAL: TO WALK BETTER WITH NO 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
* 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

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

02/25/2026

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PT WK1: 2 (02/25/26-02/28/26) ,WK2: 2 (03/01/26-03/07/26) ,WK3: 2 (03/08/26-03/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170P1 - Picking Up Object, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, GG0170F1 - Toilet Transfer, 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

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, cough/deep breathing exercises, equipment training, 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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal 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 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

Walk 150 Feet - 04. Supervision or touching assistance

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

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

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

4 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 - 02. Substantial/maximal assistance

Eating - 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

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

12 Steps - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

Medication Review

Signature of Physician:

Date

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

Date
02/25/2026