Home Health Certification and Plan of Care

Order ID: 1150/16826

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
64123088	03/04/2026	From: 03/04/2026 To: 05/02/2026	22472	217058

6. Patient's Name and Address
Richard Wagner
2205 Huntfield Ct,
Gambrills, MD 21054-
301-252-7078

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 10/17/1943 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	03/04/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	03/04/26
E78.00	Pure hypercholesterolemia unspecified	03/04/26
I10.	Essential (primary) hypertension	03/04/26
J30.9	Allergic rhinitis unspecified	03/04/26
I71.40	Abdominal aortic aneurysm without rupture unspecified	03/04/26
R73.03	Prediabetes	03/04/26

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

Simvastatin - Simvastatin 40 mg / 1 tablet by mouth in the evening cholesterol
LISINIPRIL 20 mg / 1 tablet by mouth daily blood pressure
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 mg / 1 tablet by mouth as necessary take 1 - 2 tablets every 4 - 6 hours as needed for pain
Centrum Vitamin - Ascorbic Acid: Biotin: Cyanocobalamin: Ergocalciferol: Folic Acid: Niacinamide: Pantothenic Acid: Phytonadione: Pyridoxine: Ribo 1 tablet by mouth once a day supplement
Fiber - Benefiber 2 tablets by mouth in the evening supplement
Calcium With Vitamin D - Calcium Acetate 1 tablet by mouth in the evening
Asa 81 Mg - Aspirin 81mg / 1 tablet by mouth twice a day post right hip replacement
Acetaminophen - Acetaminophen 500 mg / 1 tablet by mouth as necessary give 2 tablets every 8 hours as needed for pain

14. DME and Supplies:
cane, walker

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

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
amoxicillin

18.A. Functional Limitations
Endurance, Ambulation

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 an 82-year-old male status post right total hip replacement (RTHR) performed on 03/02/2026, who returned home the following day with assistance from family members. His past medical history is significant for hypertension (HTN), prediabetes, and hypercholesterolemia. Skilled nursing services are ordered at a frequency of once weekly for two weeks, and a physical therapy evaluation has been completed. The patient resides at home with family support, and his spouse assists with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. The patient is considered homebound due to the need for assistance from another person and the use of an assistive device to safely leave the home. During the nursing assessment, the patient was alert and oriented to person, place, and time (A&O 3). He reported postoperative right hip pain rated at 3/10 and stated that he had taken his prescribed pain medication prior to the visit with good relief. He denied shortness of breath, and lung sounds were clear throughout on auscultation. The patient reported a good appetite and stated that his last bowel movement occurred earlier that day. Inspection of the right hip surgical site revealed an anterior dressing that was clean, dry, and intact without visible drainage. The patient is currently ambulating with the use of a walker for safety. <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-Medications">Medications</mh> were reviewed in detail with the patient and spouse, including dosage, frequency, and potential side effects. Education was provided regarding effective pain management strategies and postoperative care instructions within the home environment. Both the patient and spouse verbalized understanding of the instructions provided. A physical therapy evaluation was also completed. The patient presents with right hip pain, decreased strength in the right hip, reduced functional mobility, unsteady gait, decreased balance, difficulty with transfers, and difficulty negotiating steps. He also has decreased safety awareness and a history of falls, placing him at an increased risk for additional falls and functional decline without skilled intervention. During the session, the patient required minimal assistance to standby assistance for safe transfers using a walker, with verbal cues provided for appropriate hand and foot placement, forward weight shift, and reaching back for the chair prior to sitting. The patient ambulated on level surfaces with a walker under standby assistance and received cues for proper positioning within the walker, improved bilateral step height and length, and general safety awareness. He was instructed to use the walker at all times for ambulation. Therapeutic exercises were initiated and performed in the supine position, including ankle pumps, quadriceps sets, and gluteal sets (1 set of 20 repetitions each), as well as heel slides (1 set of 10 repetitions). Passive range of motion (PROM) of the right hip was performed in the supine position as tolerated. A copy of the home exercise program (HEP) was left in the home with instructions to complete exercises twice daily. The patient was educated on the importance of daily ambulation to promote circulation and prevent complications related to inactivity, with instructions to begin a walking program consisting of short walks every 1-2 hours within the home, initially lasting 3-5 minutes and gradually increasing as tolerated. Additional education was provided regarding edema management, including elevating the lower extremities above heart level during rest periods and the potential use of compression garments if recommended by the physician. The patient and caregiver were also instructed on recognizing signs and symptoms of infection at the surgical site, including fever, chills, redness, swelling, increased pain, bleeding, or drainage, as well as persistent nausea, vomiting, or pain unrelieved by medication. Education was reinforced regarding fall prevention strategies, home safety modifications, and common fall risk factors. Pain management education included taking prescribed pain medication at the onset of discomfort, monitoring for potential side effects such as dizziness or constipation, and contacting emergency services or the provider for chest pain, unrelieved pain, or shortness of breath. The patient was also instructed to take pain medication approximately one hour prior to physical therapy sessions to improve tolerance to activity. Postoperative total hip precautions were reviewed, including weight-bearing as tolerated (WBAT), avoiding hip flexion greater than 90 degrees, avoiding combined hip flexion with external rotation, and avoiding combined hip extension with external rotation. The patient was instructed to apply ice to the right hip for 20 minutes at a time with an appropriate barrier and to assess skin integrity every five minutes during application. Pain is currently well controlled with the prescribed medication regimen. The physical therapy plan of care was reviewed and developed collaboratively with the patient and caregiver, both of whom agreed to the proposed plan. The patient will receive home physical

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/04/2026

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 : 02/18/2026

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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therapy services beginning 03/04/2026 at a frequency of three times per week for two weeks. Care coordination was completed with PTA Foster for follow-up <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh>. The patient is scheduled to begin outpatient physical therapy on 03/16/2026 and has a follow-up appointment with PA Mena on 03/18/2026. Continued skilled nursing and physical therapy services are indicated to promote healing, improve strength and mobility, reduce fall risk, and restore the patient's prior level of independence within the home environment.
 Date of Order 03/04/2026 Orders Physician Face-to-Face Date: 02/18/2026 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 (03/04/26-03/07/26) ,WK2: 1 (03/08/26-03/14/26)

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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, limited strength, limited range of motion, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, bruising/discoloration, #1 - Non-Observable Surgical Wound - Anterior Right Hip - dressing intact

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Hip - dressing intact: SN TO REMOVE RIGHT HIP DRESSING POST OP DAY 7, cough/deep breathing exercises, incentive spirometer

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 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
* 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

03/04/2026

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PT WK1: 3 (03/04/26-03/07/26) ,WK2: 3 (03/08/26-03/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170N1 - 4 Steps, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170F1 - Toilet Transfer, 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: train caregiver(s) to perform medical/rehabilitation treatments: HEP, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, Seated-LAQ, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, leg curls., therapeutic modalities: Pt instructed to apply ice to R hip x 20 minutes with necessary barrier and skin assessments q 5 minutes., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 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, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: I just want the pain to go away so I can walk better

GOALS

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 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

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/04/2026