Home Health Certification and Plan of Care

Order ID: 1150/16837

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
25183242	03/04/2026	From: 03/04/2026 To: 05/02/2026	21343	217058

6. Patient's Name and Address

Tina Freeman
9420 Fens Hollow,
LAUREL, MD 20723-
240-841-6082

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 01/08/1967 | **9.Sex** Female

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
M17.0	Bilateral primary osteoarthritis of knee	03/04/26
I10.	Essential (primary) hypertension	03/04/26
I48.0	Paroxysmal atrial fibrillation	03/04/26
I73.89	Other specified peripheral vascular diseases	03/04/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	03/04/26
D50.9	Iron deficiency anemia unspecified	03/04/26
E66.01	Morbid (severe) obesity due to excess calories	03/04/26
Z68.33	Body mass index [BMI] 33.0-33.9 adult	03/04/26
Z79.01	Long term (current) use of anticoagulants	03/04/26
Z98.84	Bariatric surgery status	03/04/26

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

Butrans - Buprenorphine 07.5 mcg/hour TD Weekly Patch / 1 Patch transdermal once a week Apply 1 patch to skin every 7 days
Lanoxin - Digoxin 0.125 mg / 1 tablet by mouth once a day
Klor-Con M20 - Potassium Chloride 20meq by mouth once a day Take 1 tablet daily with a meal (Swallow tablet whole or dissolve in water)
Cyanocobalamin (VITAMIN B-12) Injection 1,000 mcg 1,000 mcg intramuscular Monthly once every four weeks.
Narcan - Naloxone Hydrochloride 4 mg/actuation Nasal Spray Nasal as necessary Spray contents in 1 nostril for adult or child not breathing or responding. Call 911.
If patient still not breathing/responding, use new spray in 2 to 3 minutes in other nostril. For suspected opioid overdose use only
Wellbutrin Sr - Bupropion Hydrochloride 150 mg / 1 tablet by mouth twice a day Take One tablet by mouth once daily for 3 days and then one tablet by mouth twice a day as directed by pain psychologist
Tenormin - Atenolol 25 mg / 1 tablet by mouth once a day replaces diltiazem
Lasix - Furosemide 80 mg 80 mg / 1 tablet by mouth once a day Take 1 and one-half tablets by mouth daily (80 mgs in the morning and 40 mgs in the evening)
Pradaxa - Dabigatran Etexilate Mesylate 150 mg / 1 capsule by mouth twice a day
Voltaren - Diclofenac Sodium 1 percent gel topical twice a day apply 2 gms to affected area(s)
Multivitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tablet by mouth once a day
Lyrica - Pregabalin 150 mg 150mg=1 tab by mouth twice a day Take 1 capsule by mouth 2 times a day
Asa 81 Mg - Aspirin 81mg by mouth twice a day 1 tab twice daily for cardiac prevention
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth every 6 hours 1`2 tabs every 6 hours as needed for pain
Extra Strength Tylenol - Acetaminophen 500mg tabs by mouth every 6 hours 2 tabs every 6 hours as needed for pain
Colace - Docusate Sodium 100mg by mouth twice a day 1 tab twice daily for constipation

14. DME and Supplies:

rolling walker, hand held shower, bath bench, walker, grab bars, commode, cane, 4 wheeled walker

15. Safety Measures:

walker precautions, smoke detectors , medication safety, fall precautions, bleeding precautions, ambulates with device, transfer with assist, supervision at all times, hip precautions, emergency phone # clearly displayed, ambulates with assistance, standard precautions, hand rails, cardiac precautions, bathroom safety, anticoagulant precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

bupropion oxycodone

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Up As Tolerated, 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

family/caregiver will be responsible for managing treatment

Homebound status: After undergoing Right 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 59-year-old female who underwent a right total hip replacement on 03/02/2026 and is currently recovering at home. She resides in a townhome in Laurel, Maryland, with her husband and daughter, and there are multiple steps at the front entrance of the home. Her husband serves as her primary caregiver. Her past medical history is significant for long-term anticoagulant therapy, severe obesity (BMI 40-44.9), history of gastrointestinal bypass/anastomosis, hypertension, musculoskeletal pain, elevated ANA titer, paroxysmal atrial fibrillation (managed with flecainide since October 2016 and diltiazem, with EKG and creatinine monitored every six months), presence of a Mirena IUD, venous stasis edema with ulcer of both lower extremities, iron deficiency anemia, varicose veins of both legs, and a history of gastric bypass surgery. The patient has documented allergies to bupropion, which caused an extensive itchy rash and metallic taste, and oxycodone, which caused dizziness and an unusual sensation, although she is able to tolerate Ultram. On assessment, the surgical incision is covered with an Aquacel dressing with no signs or symptoms of infection, and her pain is currently well controlled. All prescribed medications are available in the home, and a MOLST form is on file indicating full code status. During the physical therapy evaluation, the patient demonstrated bilateral lower

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 : 02/25/2026

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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extremity weakness, with right lower extremity strength at 3/5 and left lower extremity strength at 3+/5, along with a painful left knee, impaired standing balance graded as fair, and an antalgic gait pattern with decreased stance time on the left and reduced step length on the right. Bed mobility requires moderate assistance with increased time and effort, while sit-to-stand and toilet transfers require moderate to maximum assistance due to weakness and pain. The patient was able to ambulate 15 feet with a rolling walker and minimal assistance, demonstrating slow cadence and impaired weight shifting. She requires an assistive device and caregiver assistance to safely exit the home and is unable to negotiate stairs without significant difficulty, meeting homebound criteria due to pain, weakness, fall risk, and the considerable effort required to leave the home. Skilled home health physical therapy is medically necessary to address strength deficits, improve balance and gait mechanics, progress functional mobility, reduce fall risk, and facilitate a safe transition to outpatient rehabilitation following the total hip replacement protocol.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 03/04/2026
 Physician Face-to-Face Date: 02/25/2026
 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right 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>
 1 - SOC - SN Notes:
 PT Eval Notes: <span style="font-size: 10.5pt; background-image: initial; background-position: initial; background-size: initial; background-repeat: initial; background-attachment: initial; background-origin: initial; background-clip: initial;"><o:p></o:p> Physician: Huang, James

SN Careplans

SN WK1: 1 (03/04/26-03/07/26)

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: 2. Non-agency caregiver(s) need training/supportive services to 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin, M1400 - Dyspnea, dependent edema, limited endurance, swelling of affected area, limited range of motion, muscle weakness, limited strength, Pain Effect on Sleep, balance deficit, difficulty sleeping, daytime fatigue, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Other - Right Hip - Right total hip replacement surgical wound covered by aquacel dressing.

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Right Hip - Right total hip replacement surgical wound covered by aquacel dressing.: 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., incentive spirometer, teach/coordinate/arrange medication packaging and/or administration

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,

SN Goals

PATIENT-STATED GOAL: Patient states she wants to get up and down her steps in her home to be able to sleep in her bed

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/caregiver recalls
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

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

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/04/2026

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medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 2 (03/04/26-03/07/26) ,WK2: 3 (03/08/26-03/14/26) ,WK3: 1 (03/15/26-03/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: HEP: Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover. , Medication Review-: Patient verbalized understanding of current prescriptions, dosages, and schedule. No reported issues with adherence, side effects, or confusion at this time. , equipment training, work simplification/energy conservation, 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 relaxation skills and diversional activities, related medication(s) purpose, schedule, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To have a successful Post opp

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

Picking Up Object - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

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 10 Feet - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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