

Home Health Certification and Plan of Care				Order ID: 1150/17244	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
13135372		03/18/2026		From: 03/18/2026 To: 05/16/2026	
4. Medical Record No.			5. Provider No.		
22961			217058		
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Orlando Holmes 9100 Brunners Run Ct, Columbia, MD 21045- 540-361-8500			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
11/21/1981			Male		
11. ICD		Principal Diagnosis		Date	
Z47.1		Aftercare following joint replacement surgery		03/18/26	
13. ICD		Other Pertinent Diagnoses		Date	
Z96.641		Presence of right artificial hip joint		03/18/26	
M19.071		Primary osteoarthritis right ankle and foot		03/18/26	
N46.01		Organic azoospermia		03/18/26	
K57.30		Dvrtclos of Ig int w/o perforation or abscess w/o bleeding		03/18/26	
R73.03		Prediabetes		03/18/26	
E66.9		Obesity unspecified		03/18/26	
Z68.34		Body mass index [BMI] 34.0-34.9 adult		03/18/26	
Z79.85		Lng trm (crnt) use injectable non-insulin antidiabetic drugs		03/18/26	
Z86.0100		Personal history of colonic polyps		03/18/26	
Z87.891		Personal history of nicotine dependence		03/18/26	
14. DME and Supplies:			15. Safety Measures:		
walker, rolling walker, hand held shower, 4 wheeled walker			walker precautions, ambulates with device, bathroom safety, emergency phone # clearly displayed, hip precautions, smoke detectors , restricted ROM, , supervision at all times, transfer with assist, , , activity supervision		
16. Nutrition:			17. Allergies:		
Z. NO PHYSICIAN-ORDERED DIET			clindamycin		
18.A. Functional Limitations			18.B. Activities Permitted		
Ambulation, Endurance			Walker, Exercises Prescribed, 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: 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.			family/caregiver 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:<div>The patient is a 44-year-old male, 24 hours status post right total hip replacement performed on 03/16/2026, with a past medical history significant for pre<mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-18 CE-FMS-diabetes">diabetes</mh>, obesity, and right ankle arthritis with prior surgical hardware. He resides in a single-family home with his wife, who serves as his primary caregiver, and is currently staying on the second floor, which requires navigation of approximately 15 steps. At the time of evaluation, the patient presents with right lower extremity weakness (RLE 3-/5, LLE 4/5), impaired standing balance graded as Fair, and an antalgic gait pattern with decreased stance time on the right. He is able to ambulate limited household distances of less than 25 feet using a walker and is utilizing cryotherapy with a schedule of 20 minutes on and 20 minutes off to assist with pain and swelling management. Pain is currently well controlled with 5 mg oxycodone. The patient requires minimal to moderate assistance for transfers due to pain and decreased weight-bearing tolerance, resulting in impairments in bed mobility, transfers, and safe ambulation. The surgical incision to the right hip is covered with an intact Aquacel dressing that is clean and dry, with mild bruising and swelling noted, but no signs of infection such as redness, warmth, drainage, or odor, consistent with expected postoperative healing. All prescribed medications are present in the home, and the patient reports no known drug allergies (NKDA) and is designated as full code. Comprehensive education was provided regarding medication management, including proper dosing, timing, and purpose of prescribed analgesics and any anticoagulants, along with potential side effects such as dizziness, constipation, and bleeding risk. The patient was instructed to adhere to the prescribed regimen and to promptly report any adverse symptoms to his physician. Additional education included safe use of an assistive device, fall prevention strategies, and postoperative precautions to protect the surgical hip. Skilled home health physical therapy is medically necessary to address deficits in strength, balance, functional mobility, transfers, and gait in order to restore independence and reduce the risk of postoperative complications. The plan of care includes therapeutic exercise, gait training, balance training, and functional mobility retraining. Nursing services are scheduled to discontinue prior to the initiation of outpatient therapy and will return at approximately 7 days postoperatively for surgical dressing removal. The patient is anticipated to transition to outpatient physical therapy within 2-3 weeks to continue progression toward prior level of function.</div><div> </div><div>Date of Order</div><div>03/18/2026</div><div>Orders</div><div>Physician Face-to-Face Date: 02/27/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right total hip replacement</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div> </div><div>PT Eval Notes: eval</div><div>PT Eval Notes: eval</div><div>Physician</div><div>Huang , James</div></div>					
SN Careplans			SN Goals		
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 03/18/2026					
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 8028 Ritchie Hwy Pasadena, MD 21122 PHONE: 410-737-5600 FAX: 14107375391 NPI: 1154567709			F2F date : 02/27/2026		
27. Attending Physician's Signature and Date Signed			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.		
Date of physician last face-to-face			PAGE 1 of 3		

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SN WK1: 1 (03/18/26-03/21/26) ,WK2: 1 (03/22/26-03/28/26)	PATIENT-STATED GOAL: Patient states he wants to get back to tinkering around the house again without any hip 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 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
CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance	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
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion	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
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.	patient/caregiver recalls * strategies to minimize fatigue and exhaustion including work simplification * energy conservation * lifestyle changes * diet * recalls related medication(s) purpose, schedule
; 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	patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule
PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, swelling of affected area, limited range of motion, limited endurance, limited strength, muscle weakness, Pain Effect on Sleep, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, bruising/discoloration, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Other - Right hip - Right hip surgical incision from THA	caregiver administers and/or packages medications appropriately
PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - Right hip - Right hip surgical incision from THA: 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, 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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, 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 Goals
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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	03/18/2026

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PT WK1: 2 (03/18/26-03/21/26) ,WK2: 3 (03/22/26-03/28/26) 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: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover. , B LE mm strengthening, 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, 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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, 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-STATED GOAL: To have a successful post surgical outcome GOALS Chair to Bed to Chair - 06. Independent Toilet Transfer - 06. Independent Sit to Stand - 06. Independent Car Transfer - 06. Independent Walk 50 ft with 2 Turns - 06. Independent Walk 150 Feet - 06. Independent 12 Steps - 06. Independent Picking Up Object - 06. Independent Lower Body Dressing - 06. Independent Don/Doff Footwear - 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 - 06. Independent Walk 10 ft on Uneven Surface - 06. Independent 1 - Step (curb) - 06. Independent 4 Steps - 06. Independent Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Shower/Bathe Self - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent	

Signature of Physician:	Date
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