Home Health Certification and Plan of Care

Order ID: 1150/18497

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
211303076	05/06/2026	From: 05/06/2026 To: 07/04/2026	25371	217058

6. Patient's Name and Address
Kelly Zimmerman
2401 Brambleton Rd,
BALTIMORE, MD 21209-
443-622-4340

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 10/04/1977 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	05/06/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	05/06/26
M47.896	Other spondylosis lumbar region	05/06/26
J45.20	Mild intermittent asthma uncomplicated	05/06/26
E06.3	Autoimmune thyroiditis	05/06/26
E04.1	Nontoxic single thyroid nodule	05/06/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/06/26
Q79.62	Hypermobile Ehlers-Danlos syndrome	05/06/26
Q79.59	Other congenital malformations of abdominal wall	05/06/26
Q65.89	Other specified congenital deformities of hip	05/06/26
L30.1	Dyshidrosis [pompholyx]	05/06/26
F33.9	Major depressive disorder recurrent unspecified	05/06/26
F41.1	Generalized anxiety disorder	05/06/26
E66.9	Obesity unspecified	05/06/26
Z68.33	Body mass index [BMI] 33.0-33.9 adult	05/06/26
Z87.891	Personal history of nicotine dependence	05/06/26

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

SINGULAIR 10 mg / 1 Tablet by mouth every evening
CYMBALTA Delayed Release 30 mg / 1 Capsule by mouth once a day
Increase to 60 mg (2 capsules) after 1 week
CYTOMEL 5 mcg / 1 Tablet by mouth daily
Synthroid - Levothyroxine Sodium 125 mcg / 1 Tablet by mouth every morning 30 minutes before a meal
BUSPAR 5 mg / 1 Tablet by mouth 2 times a day
PROMETRIUM 100 mg/capsule / Take 2 capsules by mouth daily
MULTIVITAMIN 1 Tablet by mouth daily
Colace - Docusate Sodium 100mg by mouth twice a day 1-2 tabs for stool softners
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 4 hours Post surgical pain
Tylenol #3 - Acetaminophen: Codeine Phosphate 500mg by mouth every 6 hours Anti-inflammatory
Cpap - Cpap 4.0 inhalant at bedtime OsA
Zofran Odt - Ondansetron 4 mg / Dissolve 1 tablet on the tongue sublingual every 8 hours as needed for nausea or vomiting
CLIMARA 0.05 mg/24hr Patch / Apply 1 patch to skin transdermal once a week
ESTRACE 0.01% Vaginal Cream / Insert 1 Gram vaginal two times per week

14. DME and Supplies:
walker, cane, sock aid

15. Safety Measures:
walker precautions, standard precautions, supervision at all times, bathroom safety, hip precautions, fall precautions, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:
regular,

17. Allergies:
penicillins

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Up As Tolerated, Cane, Walker

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: 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 Right total hip arthroplasty, 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:

Start of care completed with consents signed by the patient. Patient is a 49-year-old female status post right total hip arthroplasty performed this week by Dr. Huang. Patient remains homebound due to recent right hip joint replacement surgery, impaired mobility, postoperative weakness, pain, and need for walker assistance with one-person support for safety and fall prevention. Prior to surgery, patient was independent with ambulation without an assistive device, occasionally using a single-point cane as needed. Past medical history is significant for sleep apnea, hypothyroidism, seasonal allergies, and anxiety. Patient is alert and oriented x4. Surgical follow-up appointment is scheduled for 05/18/2026 with Mena. Patient reports pain level of 2/10 following physical therapy visit. Patient ambulates with rolling walker for safety and denies any recent falls. Patient reported last bowel movement occurred two days ago. Skilled nursing provided education regarding bowel regimen management, including use of stool softeners, increased hydration, and monitoring for constipation related to oxycodone use. Patient reported appetite is not yet back to baseline but is eating adequately to take medications. Patient denied nausea, urinary discomfort, or abnormal bleeding. Patient reported intermittent dizziness and lightheadedness, and was instructed on slow position changes from lying to sitting and sitting to standing to reduce fall risk and orthostatic symptoms. Patient utilizes CPAP therapy at a setting of 4.0 for management of sleep apnea and reports sleeping well. Patient's mother, Leah, is present in the home and serves as the primary caregiver. Surgical dressing remains intact with no additional wounds identified during assessment. Skilled nursing instructed patient on incision and dressing care, including avoiding soaking or getting the dressing wet. Patient was educated to immediately notify the surgeon for any increase in bruising, pain, swelling, drainage, fever, or signs of infection. Patient verbalized understanding of all teaching provided. Incentive spirometer use was demonstrated and reinforced to promote pulmonary hygiene. No abnormal lung sounds were noted during assessment. All medications were reviewed with the patient, including education regarding pain management, appropriate use of anti-inflammatory medications, and use of ice therapy as directed for swelling and discomfort control. Physical therapy evaluation revealed decreased right lower extremity strength with manual muscle testing graded at 2-/5 secondary to postoperative stiffness and weakness. Patient currently requires contact guard assistance for transfers and short-distance ambulation using a rolling walker. Verbal cueing was required to improve gait sequencing, trunk extension, and step length during ambulation. Patient was instructed in an initial home exercise program consisting of seated therapeutic exercises and stretching focused on hip flexion and extension to improve range of motion and mobility. Skilled physical therapy services are medically necessary to address postoperative weakness, decreased range of motion, impaired gait mechanics, reduced endurance, balance deficits, and safety with mobility in order to restore prior level of function and reduce fall risk. Skilled nursing frequency ordered for 1 visit weekly for 2 weeks. Continued skilled nursing services are indicated for postoperative assessment, incision monitoring, pain management, medication education, cardiopulmonary assessment, fall prevention education, bowel regimen monitoring, and reinforcement of safety precautions. During the next nursing visit, dressing removal, incision assessment, wound measurements, and wound photography will be completed as ordered.
 Date of Order 05/06/2026 Orders Physician Face-to-Face Date: 04/15/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval &

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/06/2026

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 : 04/15/2026

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.

Home Health Certification and Plan of Care

Order ID: 1150/18497

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
211303076	05/06/2026	From: 05/06/2026 To: 07/04/2026	25371	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Kelly Zimmerman 2401 Brambleton Rd, BALTIMORE, MD 21209- 443-622-4340	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

treat due to Right total hip arthroplasty 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 (05/06/26-05/09/26) ,WK2: 1 (05/10/26-05/16/26)

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; 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.

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.
Advance Directive:Na

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, M1400 - Dyspnea, swelling of affected area, limited range of motion, Pain Interference with Therapy activities, Pain Interference with ADLs, pain radiating to arms/legs, Pain Effect on Sleep, balance deficit, loss of appetite, #1 - Non-Observable Surgical Wound - Anterior Right Hip - , red/tender pressure points, swell/redness surround. skin

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Hip -, cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

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

SN Goals

PATIENT-STATED GOAL: Pain management and Regain mobility and independence

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
* 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
* 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/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

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/06/2026

Home Health Certification and Plan of Care

Order ID: 1150/18497

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
211303076	05/06/2026	From: 05/06/2026 To: 07/04/2026	25371	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Kelly Zimmerman 2401 Brambleton Rd, BALTIMORE, MD 21209- 443-622-4340	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 2 (05/06/26-05/09/26) ,WK2: 3 (05/10/26-05/16/26) ,WK3: 1 (05/17/26-05/23/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: seated knee ext, hip flex below 90 degrees, hip abd, quad sets, gluteal squeezes, ankle pumps at least 1x10. Once tolerated, upgrade to standing heel/ toe raises, knee flex, hip flex below 90 degrees, hip abd at least 1x10 with UE support as needed, equipment training, 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 - 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 - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent, Medication Review

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

GOALS
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

Toileting Hygiene - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

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 - 04. Supervision or touching assistance

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

4 Steps - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 06. Independent

Eating - 06. Independent

Medication Review

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

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

Walk 150 Feet - 04. Supervision or touching assistance

12 Steps - 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	05/06/2026