Home Health Certification and Plan of Care

Order ID: 1150/18642

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
31151192	05/11/2026	From: 05/11/2026 To: 07/09/2026	23436	217058

6. Patient's Name and Address

Bonnie Blottenberger
1222 Maiden Choice Ln,
BALTIMORE, MD 21229-
410-303-9967

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 02/05/1950 | **9.Sex** Female

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

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	05/11/26
E11.65	Type 2 diabetes mellitus with hyperglycemia	05/11/26
I10.	Essential (primary) hypertension	05/11/26
E78.00	Pure hypercholesterolemia unspecified	05/11/26
I70.0	Atherosclerosis of aorta	05/11/26
M19.012	Primary osteoarthritis left shoulder	05/11/26
M10.9	Gout unspecified	05/11/26
I05.0	Rheumatic mitral stenosis	05/11/26
E04.2	Nontoxic multinodular goiter	05/11/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/11/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	05/11/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	05/11/26
Z79.01	Long term (current) use of anticoagulants	05/11/26
Z79.891	Long term (current) use of opiate analgesic	05/11/26
Z85.3	Personal history of malignant neoplasm of breast	05/11/26
Z85.820	Personal history of malignant melanoma of skin	05/11/26
Z90.13	Acquired absence of bilateral breasts and nipples	05/11/26

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

LYRICA 100 mg / 1 Capsule by mouth twice a day Take 2 capsules
COZAAR 100 mg / 1 Tablet by mouth once a day
Drisdol - Ergocalciferol 50,000 International Units / 1 Capsule by mouth once a week every 7 days
Lopressor - Metoprolol Tartrate 25 mg / 1 Tablet by mouth twice a day
Glucotrol - Glipizide 5 mg / 1 Tablet by mouth once a day
Pradaxa - Dabigatran Etexilate Mesylate 150 mg / 1 Capsule by mouth twice a day
Zyloprim - Allopurinol 300 mg / 1 Tablet by mouth once a day for gout
Norvasc - Amlodipine Besylate eq 10 mg base / 1 Tablet by mouth once a day for HTN (Hold for SBP over 110 or HR less than 60)
Jardiance - Empagliflozin 25 mg / 1 Tablet by mouth in the morning Take half tablet
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25 mcg (1,000 unit) Oral Tab / Take 1,000 units by mouth once a day
Tylenol - Acetaminophen 500 mg by mouth every 6 hours as needed for pain
Effexor Xr - Venlafaxine Hydrochloride eq 150 mg base / 1 Capsule by mouth once a day for Depression in addition to 75mg as directed
Effexor Xr - Venlafaxine Hydrochloride eq 75 mg base / 1 Capsule by mouth once a day (Take with 150mg capsule to equal 225mg) for depression
Lipitor - Atorvastatin Calcium eq 20 mg base / 1 Tablet by mouth once a day for Hyperlipidemia for cholesterol and heart protection
Vibramycin - Doxycycline 100 mg / 1 capsule by mouth twice a day Take 1 capsule by mouth two (2) times daily for Toe Cellulits and purulent drainage for 2 days as per directed
Narcan - Naloxone Hydrochloride 4 mg / actuation nasal spray inhalant 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

14. DME and Supplies:

wheelchair, bath bench, cane, walker

15. Safety Measures:

supervision at all times, standard precautions, hip precautions, walker precautions, wheelchair precautions, diabetic precautions, fall precautions, bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

regular, low sodium, low cholesterol, ,

17. Allergies:

codeine morphine

18.A. Functional Limitations

Ambulation,

18.B. Activities Permitted

Cane, Walker, , 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:

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

SN: patient will be responsible for managing treatment
PT: family/caregiver will be responsible for managing treatment
OT: family/caregiver 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:

Start of care assessment completed with all consents signed by the patient. Patient is a 76-year-old female status post left total hip replacement performed by Dr. Huang approximately three weeks ago. Following postoperative follow-up, the patient bent forward and experienced left hip dislocation. During rehabilitation, the hip reportedly dislocated again while getting out of bed, resulting in revision surgery with placement of a three-part hip joint prosthetic component to improve flexibility and reduce risk of recurrent dislocations. Past medical history is significant for diabetes mellitus, hypertension, hypercholesterolemia, gout, breast cancer status post double mastectomy, melanoma, sclerosis, and chronic back pain. Patient resides with her husband, Don, in a single-family home with five steps required to enter the residence and bedroom and bathroom located on the second floor. Husband serves as the primary caregiver and assists with homemaking tasks. Prior to recent surgeries, patient was independent with basic self-care tasks and mobility. At the time of assessment, patient was alert and oriented x4, pleasant, and cooperative with care. Patient denied current hip pain, dizziness, lightheadedness, nausea, vomiting, urinary discomfort, or recent falls. Patient reported chronic back pain rated at 5/10 related to sclerosis. Appetite was noted to be slowly improving, with patient reporting increased oral intake and consumption of two plates of food the previous evening. Last bowel movement occurred yesterday. Hydration education was provided to prevent dehydration, and patient reported drinking adequate amounts of water daily. Patient ambulates with a rolling walker for safety and fall prevention and requires taxing effort to leave the home, supporting homebound status. Patient ambulated approximately 40 feet twice on indoor surfaces with close supervision and was able to negotiate 14 stairs using a handrail and cane with supervision. Bed mobility requires moderate assistance at the lower extremities secondary to back pain. Transfers from bed and chair to standing are performed with supervision. Tinetti balance assessment score was 15/28, indicating elevated fall risk. Skilled instruction was provided regarding hip precautions, specifically avoiding bending greater than 90 degrees, as well as reinforcement of both anterior and posterior hip precautions related to activities of daily living and bed mobility. Patient verbalized understanding of all teaching provided. Physical assessment revealed lungs clear to auscultation bilaterally. Surgical incision was assessed and measured, noted to be healed and open to air, with photograph obtained for documentation. All medications were reviewed with the patient and caregiver. Skilled nursing

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/11/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Tracy Gutierrez
7070 Samuel Morse Dr
Columbia, MD 21046
PHONE: FAX: NPI: 1336113091

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 : 03/10/2026

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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education included pain management strategies, appropriate use of prescribed anti-inflammatory medications, and use of ice therapy as directed. Patient tolerated therapeutic exercises including 10 repetitions each of supine hip flexion, bridging, quadriceps sets, gluteal sets, seated knee extensions, and ankle pumps. Occupational therapy evaluation determined patient would benefit from continued intervention focused on ADL retraining, adaptive equipment training, therapeutic exercise, home exercise program instruction, functional mobility training, safety education, and caregiver training. Physical therapy services were also recommended to improve strength, mobility, endurance, safety, and return patient to maximal level of independence, though progress may be limited by chronic back pain. Skilled nursing frequency planned for 1 visit weekly for 4 weeks, then 1 visit weekly for 2 additional weeks, with PT and OT services ordered.
 Date of Order 05/11/2026 Orders Physician Face-to-Face Date: 03/10/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control, PT-eval & treat, OT-eval & treat due to Left 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: OT Eval Notes:
 Physician Gutierrez, Tracy

SN Careplans

SN WK1: 1 (05/11/26-05/16/26) ,WK2: 1 (05/17/26-05/23/26) ,WK3: 1 (05/24/26-05/30/26) ,WK4: 1 (05/31/26-06/06/26) ,WK6: 1 (06/14/26-06/20/26) ,WK8: 1 (06/28/26-07/04/26)

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: 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 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.

No open wounds noted
Advance Directive:NA

PROBLEMS IDENTIFIED ON ASSESSMENT: meal preparation, M2020 - Oral Med Management, abn cholesterol > 200 mg/dL, M1400 - Dyspnea, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, limited range of motion, limited endurance, limited strength, balance deficit, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, pain radiating to arms/legs, daytime fatigue, loss of appetite, swell/redness surround. skin

PROCEDURES: cough/deep breathing exercises, wound vacuum, glucose testing via monitor: Glipizide and diet management, 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, 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 improve walking

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

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

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/11/2026

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PT Careplans

PT WK1: 2 (05/11/26-05/16/26) ,WK2: 2 (05/17/26-05/23/26) ,WK3: 2 (05/24/26-05/30/26) ,WK4: 2 (05/31/26-06/06/26) ,WK5: 2 (06/07/26-06/13/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair

PROCEDURES: Bed mobility training : Sit to supine and supine to sit., Family training with husband: Bed mobility and home program, home exercise program: Supine quad sets, glut sets, hip flexion, bridging. Sitting knee extension, ankle pumps. Standing knee flexion, hip abduction, plantarflexion, squats, gait training on uneven surfaces, 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, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet 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, Car Transfer - 05. Setup or clean-up assistance

PT Goals

PATIENT-STATED GOAL: For my back to stop hurting and walk like normal

GOALS
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

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

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 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

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

Car Transfer - 05. Setup or clean-up assistance

Walk 10 Feet - 05. Setup or clean-up assistance

OT Careplans

OT WK1: 4 (05/11/26-05/16/26) ,WK2: 4 (05/17/26-05/23/26)

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

PROCEDURES: cough/deep breathing exercises, home exercise program: LUE ROM, UE theraband, equipment training, work simplification/energy conservation, transfers training: Shower, toilet

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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 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, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: To recover

GOALS
Shower/Bathe Self - 05. Setup or clean-up 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

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

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

Signature of Physician:

Date

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

Date
05/11/2026