Home Health Certification and Plan of Care

Order ID: 1150/18968

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
821084771	05/12/2026	From: 05/12/2026 To: 07/10/2026	25080	217058

6. Patient's Name and Address
Benjamin Washington
110 S Tremont Rd,
Baltimore, MD 21229-
443-386-0385

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 09/17/1966 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	05/12/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	05/12/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	05/12/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	05/12/26
N18.32	Chronic kidney disease stage 3b	05/12/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/12/26
E11.69	Type 2 diabetes mellitus with other specified complication	05/12/26
E78.5	Hyperlipidemia unspecified	05/12/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/12/26
E66.9	Obesity unspecified	05/12/26
Z68.33	Body mass index [BMI] 33.0-33.9 adult	05/12/26
Z86.0101	Personal history of adeno	05/12/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	05/12/26
Z87.891	Personal history of nicotine dependence	05/12/26

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

NORVASC eq 10 mg base 10 mg / 1 Tablet by mouth daily blood pressure
Asa 81 Mg - Aspirin 81mg; 1 tab by mouth twice a day post left hip replacement
LIPITOR eq 40 mg base 40 mg / 1 Tablet by mouth every evening cholesterol
Cartia Xt - Diltiazem Hydrochloride 240 mg / 1 Tablet by mouth daily blood pressure
Colace - Docusate Sodium 100mg; 1 cap by mouth twice a day bowel regimen
PEPCID 40 mg 40 mg / 1 Tablet by mouth daily stomach
GLUCOTROL 5 mg 5 mg / 1 Tablet by mouth every morning 30 minutes before a meal for Diabetes diabetes
COZAAR 100 mg 100 mg / 1 Tablet by mouth daily blood pressure
Glucophage Xr - Metformin Hydrochloride 500 mg / 1 Tablet by mouth 2 times a day with meals for Diabetes diabetes
ACTOS eq 15 mg base 15 mg / 1 Tablet by mouth daily for diabetes DM
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50 mcg (2,000 unit) / 1 Capsule by mouth daily SUPPLEMENT
Iron,Carbonyl Vitamin C (VITRON-C) 0 Delayed Release 65 mg iron- 125 mg / 1 Tablet by mouth once a day SUPPLEMENT
REVATIO eq 20 mg base 20 mg/tablet / Take 2 to 3 tablets by mouth as necessary 1 hour prior to sexual activity. Do not exceed 3 tablets in 24 hours
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5MG; 1-2 TABS by mouth every 4 hours FOR PAIN AS NEEDED

14. DME and Supplies:
diabetic supplies, rolling walker, cane

15. Safety Measures:
standard precautions, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, transfer with assist, hip precautions, anticoagulant precautions

16. Nutrition:
diabetic,

17. Allergies:
no known allergies

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 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: The patient is a 59-year-old individual status post left total hip replacement with a past medical history significant for hypertension, diabetes mellitus, osteoarthritis of the left hip, obstructive sleep apnea requiring CPAP, hyperlipidemia, and chronic kidney disease stage 3B. The patient resides with their spouse in a row house with 10 steps required for entry, with the bedroom and bathroom located on the second floor. The spouse assists with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. Skilled nursing services are ordered at a frequency of once weekly for two weeks, along with physical therapy evaluation and treatment. Upon assessment, the patient was alert and oriented to person, place, and time and reported no pain (0/10) at the time of the visit. Pain management is being effectively controlled with prescribed oxycodone and acetaminophen (Tylenol). The patient denied shortness of breath, and lung sounds were clear throughout all fields. The patient reported the last bowel movement occurred on Friday. Examination of the left hip surgical site revealed the dressing to be clean, dry, intact, and without drainage or signs of infection. The patient is utilizing a rolling walker for safe ambulation. Functional assessment revealed the patient is able to ambulate approximately 30 feet on indoor surfaces using a rolling walker with verbal cues for proper gait pattern. The patient is capable of negotiating 14 stairs using a handrail and cane with supervision. Bed mobility requires minimal assistance for management of the left lower extremity. Transfers to and from the bed, chair, and toilet are completed with supervision. Outdoor mobility and car transfer skills were not assessed during this visit. The patient is considered homebound due to the significant effort required to leave the home with an assistive device and an elevated fall risk, as evidenced by a Tinetti Balance and Gait Assessment score of 14/28. Physical therapy interventions included instruction and performance of therapeutic exercises consisting of supine quadriceps sets, gluteal sets, hip flexion exercises, bridging, knee extensions, and ankle pumps, all of which were tolerated well. Education was provided regarding postoperative hip replacement precautions, including avoidance of hip flexion greater than 90 degrees. The patient was instructed to ambulate five times daily and to apply ice to the surgical area for 20 minutes several times per day to assist with pain and swelling management. Skilled nursing reviewed all medications, including dosages, frequencies, purposes, and pertinent side effects, and reinforced postoperative care instructions. Both the patient and caregiver demonstrated understanding of and were receptive to all education provided. The patient would benefit from continued home health skilled nursing and physical therapy services to monitor postoperative recovery, ensure medication compliance and surgical site healing, improve strength, mobility, balance, and endurance, reduce fall risk, and facilitate a safe return to the highest possible level of independence.
 Date of Order 05/12/2026 Orders Physician Face-to-Face Date: 04/30/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-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 <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/12/2026

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 : 04/30/2026

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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14px;">
 1 - SOC - SN Notes: soc PT Eval Notes: eval
 Physician Huang, James

SN Careplans

SN WK1: 1 (05/12/26-05/16/26) ,WK2: 1 (05/17/26-05/23/26)

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, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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.

LEFT HIP DRESSING
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited range of motion, limited strength, limited endurance, balance deficit, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Anterior Left Hip - LEFT DRESSING INTACT WITH NO DRAINAGE NOTED

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Hip - LEFT DRESSING INTACT WITH NO DRAINAGE NOTED: SN TO REMOVE LEFT HIP DRESSING POST OP DAY 7, physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Hip - LEFT DRESSING INTACT WITH NO DRAINAGE NOTED: SN TO REMOVE POST OP DAY 7, cough/deep breathing exercises, incentive spirometer, glucose testing via monitor: DAILY

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, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: To walk and get better

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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* 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

05/12/2026

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10 Crossroads Drive, Suite 102
Owings Mills, MD 21117-8284
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1487113239

PT WK1: 2 (05/12/26-05/16/26) ,WK2: 3 (05/17/26-05/23/26) ,WK3: 1 (05/24/26-05/30/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, GG0170O1 - 12 Steps, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170P1 - Picking Up Object, 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, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, #2 - Observable Surgical Wound - Anterior Left Hip -

PROCEDURES: physician-ordered wound care: #2 - Observable Surgical Wound - Anterior Left Hip -: Leave open to air, Bed mobility training : Sit to supine, Hip precautions training : Avoid excess hip flexion, Medication reconciliation : Assess for medication changes, Assess status of left hip wound: Take measurements when appropriate, physician-ordered wound care: Leave open to air, wound vacuum, home exercise program: Supine hip flexion, quad sets, glut sets, bridging. Standing knee flexion, hip abduction, plantarflexion, squats. Sitting knee extension, ankle pumps, equipment training, 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 05. Setup or clean-up assistance, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: Be able to get around with my cane again

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

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 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 10 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 - 02. Substantial/maximal assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

Car Transfer - 05. Setup or clean-up assistance

Upper Body Dressing - 06. Independent

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

Signature of Physician:

Date

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

Date
05/12/2026