Home Health Certification and Plan of Care

Order ID: 1150/19869

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
86220167	06/17/2026	From: 06/17/2026 To: 08/15/2026	26271	217058

6. Patient's Name and Address

Clarisa Davis
208 Benmere Rd,
Glen Burnie, MD 21060-
443-968-4736

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 05/25/1993 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S72.001D	Fx unsp part of nk of r femr subs for clos fx w routn heal	06/17/26

13. ICD	Other Pertinent Diagnoses	Date
L50.1	Idiopathic urticaria	06/17/26
M79.7	Fibromyalgia	06/17/26
I95.1	Orthostatic hypotension	06/17/26
J45.909	Unspecified asthma uncomplicated	06/17/26
E66.3	Overweight	06/17/26
Z68.33	Body mass index [BMI] 33.0-33.9 adult	06/17/26
Z87.891	Personal history of nicotine dependence	06/17/26
Z96.641	Presence of right artificial hip joint	06/17/26

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

CYMBALTA 60 mg SR 60 mg / 1 Capsule by mouth daily depression
Allegra - Fexofenadine Hydrochloride 180 mg 180 mg; 1 tab by mouth once a day allergies
FLORINEF 0.1 mg 0.1 mg / 1 Tablet by mouth daily corticosteroids
Proventil - Albuterol 90 mcg/actuation Inhl HFAA / Inhale 1 to 2 puffs by mouth every 4 hours as needed for sob
ALVESCO 0.08 mg/inh 80 mcg/actuation Inhl HFAA / Inhale1 Puff by mouth 2 times a day (controller inhaler)
Asa 81 Mg - Aspirin 81mg; 1 tab by mouth twice a day post hip replacement
Tylenol Es - Acetaminophen 500mg; 1-2 tabs by mouth as necessary as needed for pain
post op right replacement
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg; 1-2 tabs by mouth as necessary every 4-6 hours as needed for pain
Colace - Docusate Sodium 100mg; 1 tab by mouth twice a day stool softner

14. DME and Supplies:

bath bench, wheelchair, walker, cane

15. Safety Measures:

standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, ambulates with assistance, transfer with assist, supervision at all times, anticoagulant precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

latex

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Up As Tolerated, Wheelchair, 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: 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: Due to diagnosis of Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, 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:

A home health skilled nursing and physical therapy evaluation was completed for a 33-year-old female status post right total hip replacement (RTHR) performed on 06/15/2026 secondary to aseptic necrosis of the right hip, with a past medical history significant for orthostatic hypotension and prior hardware removal. The patient returned home the day following surgery and resides with her spouse, Raymond, who provides assistance most of the time, while her son, Hayden, is available continuously to assist with care needs. Upon skilled nursing assessment, the patient was alert and oriented to person, place, and time. She reported right hip pain rated at 5/10, which was effectively managed with prescribed oxycodone and acetaminophen. She denied shortness of breath, and lung sounds were clear to auscultation. The right hip surgical dressing was intact with no reported complications, and the patient was ambulating with a walker for safety. Medication reconciliation was completed, and education was provided regarding medication management, effective pain control, postoperative precautions, and recognition of complications. The patient and spouse verbalized understanding of all instructions provided. Physical therapy evaluation revealed decreased endurance and mobility following surgery, resulting in an increased risk for falls and requiring assistance from another person and an assistive device to safely leave the home, supporting homebound status. The patient presents with right hip pain, decreased right lower extremity strength, impaired functional mobility, difficulty negotiating stairs, unsteady gait, transfer deficits, impaired balance, and increased fall risk. She requires minimal assistance to standby assistance for transfers and bed mobility and standby assistance for ambulation with a walker. Skilled physical therapy is medically necessary to address strength deficits, gait abnormalities, balance impairments, transfer training, stair negotiation, functional mobility limitations, and safety awareness in order to restore the highest possible level of independence and reduce the risk of falls, further functional decline, and loss of independence. The physical therapy plan of care was reviewed and developed collaboratively with the patient and caregiver, both of whom agreed with the proposed treatment plan. The patient is scheduled to receive home physical therapy beginning 06/17/2026 with a frequency of 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> per week for 1 week, followed by 3 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> per week for 1 week, and 1 visit during the final week, with services primarily assigned to PTA David. The patient is scheduled to begin outpatient physical therapy on 06/30/2026 and has a follow-up appointment with PA Mena on 06/29/2026. Extensive education was provided regarding postoperative hip precautions, including avoidance of hip flexion greater than 90 degrees, avoidance of combined hip flexion with external rotation, and avoidance of combined hip extension with external rotation. The patient was instructed that she is weight-bearing as tolerated with an assistive device. Additional teaching included edema management strategies such as elevating the lower extremities above heart level during rest periods and utilizing compression garments if recommended by the physician. The patient and caregiver were educated on signs and symptoms of surgical site infection, including fever, chills, redness, swelling, increased pain, bleeding, drainage, persistent nausea or vomiting, and pain not relieved by medication. Functional mobility training included instruction on safe transfer techniques using a walker, emphasizing proper hand and foot placement, forward weight shift, and reaching back before sitting. Bed mobility training focused on proper body mechanics and techniques to improve independence. The patient was instructed in and performed a home exercise program consisting of ankle pumps, quadriceps sets, gluteal sets, and heel slides, and was provided with written handouts to complete exercises twice daily. Passive range-of-motion exercises to the right hip were also performed. Gait training was conducted on level surfaces with a walker, with emphasis on proper positioning within the walker, improved step height and step length, and overall safety. The patient was advised to use the walker at all times during ambulation. Education was also provided regarding the importance of daily ambulation to improve circulation and prevent complications related to inactivity. The patient was instructed to initiate a walking program consisting of short walks every 1-2 hours throughout the day and to gradually increase longer walks beginning at 3-5 minutes as tolerated. Additional pain management education included applying ice to the right hip for 20 minutes at a time using an appropriate skin barrier, monitoring skin integrity every five minutes during ice application, taking pain medication at the onset of discomfort, recognizing potential medication side effects such as dizziness and constipation, and seeking immediate medical attention for chest pain, shortness of breath, or uncontrolled pain. The patient was also advised to take prescribed pain medication approximately one hour prior to

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/17/2026

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 : 06/04/2026

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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physical therapy sessions to maximize participation and comfort. The patient demonstrated understanding of all education provided and verbalized agreement with the plan of care.
 Date of Order 06/17/2026 Orders Physician Face-to-Face Date: 06/04/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing 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 (06/17/26-06/20/26) ,WK2: 1 (06/21/26-06/27/26)

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

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.

RIGHT HIP
Advance Directive:No

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, meal preparation, dependent edema, M1400 - Dyspnea, limited range of motion, limited strength, limited endurance, balance deficit, Pain Effect on Sleep, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Other - RIGHT HIP -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - RIGHT HIP -: SN TO REMOVE DRESSING ON POST OP DAY 7, cough/deep breathing exercises, incentive spirometer

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, * 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's transportation needs are met, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: TO BE INDEPENDENT WITH WALKING

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

patient's transportation needs are met

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	06/17/2026

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PT Careplans

PT WK1: 2 (06/17/26-06/20/26) ,WK2: 3 (06/21/26-06/27/26) ,WK3: 1 (06/28/26-07/04/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, M1400 - Dyspnea, 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: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide Seated-LAQ, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, leg curls., therapeutic modalities: Apply ice to R hip x 20 minutes with necessary barrier and skin assessments q 5 minutes., equipment training: Walker and cane, gait training/stair training, transfers training, assist with infection control: Instruct Pt/PCG insigns and symptoms of infection of incision/wound, including fever, chills, redness, swelling, pain, bleeding, or any discharge from the surgical or wound site. When to notify EMS-Nausea or vomiting that does not get better, or pain that does not get better with medication., assist with fall prevention: Teach pt on Falls prevention -use recomended AD at all times and/or direct assistance by CG as needed -make sure clothing does not drag on floor to create trip hazard -proper footwear, no scuffs - Strength program has been initiated for LEs, continue 1-2x/day -carry phone at all times in case of emergency -Consider medic alert button -Fall recover technique discussed -Keep stairs free of obstacles -Maintain functional pathways throughout the home and at all exits -use night lights -Advised against holding onto towel bars or soap dishes, consider grab bars, check grab bars before use -remove scatter rugs, if one must remain use double sided rug tape -Add non skid mat in the shower -keep the floor dry in the bathroom, if using a shower seat dry self completely before stepping out.

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, 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 - 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 - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: I want to be able to get upstairs to my bedroom

GOALS
Toilet Transfer - 06. Independent

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

1 - Step (curb) - 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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

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

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

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

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

Chair to Bed to Chair - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/17/2026