

Home Health Certification and Plan of Care				Order ID: 1150/19890	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
761036205		06/17/2026		From: 06/17/2026 To: 08/15/2026	
				4. Medical Record No.	
				26316	
				5. Provider No.	
				217058	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Harri Mullenax				HomeCentris Healthcare LLC	
8135 Cyrprus Cedar Lane Apt A,				10 Crossroads Drive, Suite 102	
Ellicott City, MD 21043-				Owings Mills, MD 21117-8284	
410-812-5680				410-321-8448	
				1487113239	
8. DOB 11/19/1952 9.Sex Female				10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
11. ICD	Principal Diagnosis		Date	NORVASC eq 10 mg base 10 mg / 1 Tablet by mouth daily BLOOD PRESSURE	
Z47.1	Aftercare following joint replacement surgery		06/17/26	BIOTIN Take 10 mg by mouth daily SUPPLEMENT	
13. ICD	Other Pertinent Diagnoses		Date	Dabigatran Etexilate - Dabigatran Etexilate 110MG; 2 CAPS by mouth once a day POST HIP REPLACEMENT	
Z96.641	Presence of right artificial hip joint		06/17/26	FARXIGA 10 mg / 1 Tablet by mouth EVERY MORNING PLEASE NOTE CHANGE IN DIRECTIONS; THIS REPLACES JARDIANCE. noted 05/12/26)	
M16.12	Unilateral primary osteoarthritis left hip		06/17/26	NEURONTIN 300 mg 300 mg/capsule / Take 1 to 2 capsules by mouth twice a day PAIN	
M54.16	Radiculopathy lumbar region		06/17/26	CLARITIN 10 mg 10 mg / 1 Tablet by mouth daily as needed FOR ALLERGIES	
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny		06/17/26	COZAAR 100 mg / 1 Tablet by mouth daily BLOOD PRESSURE	
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease		06/17/26	SINGULAIR 10 mg / 1 Tablet by mouth every evening ALLERGIES	
N18.31	Chronic kidney disease stage 3a		06/17/26	OMEPRAZOLE 20 mg DR 20 MG tablet by mouth every other day STOMACH	
J30.2	Other seasonal allergic rhinitis		06/17/26	ROXICODONE 5 mg 5 mg / 1 Tablet by mouth every 4 hours as needed for pain (1-2 tabs as needed)	
M54.41	Lumbago with sciatica right side		06/17/26	Triamterene-hydroCHLORothiazide (MAXZIDE-25MG) 37.5-25 MG / 1 Tablet by mouth daily HTN	
M54.42	Lumbago with sciatica left side		06/17/26	Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin:	
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding		06/17/26	Cholecalciferol: Cyanocobalamin: Dexpantenol: Folic Acid: Niacinamide:	
K76.0	Fatty (change of) liver not elsewhere classified		06/17/26	Pyridox 25 mcg (1,000 unit) / Take 2 tablets by mouth daily SUPPLEMENT	
E11.69	Type 2 diabetes mellitus with other specified complication		06/17/26	Vitamin E - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol:	
E78.5	Hyperlipidemia unspecified		06/17/26	Cyanocobalamin: Dexpantenol: Folic Acid: Niacinamide: Pyridox Take 400	
I70.0	Atherosclerosis of aorta		06/17/26	Units by mouth daily SUPPLEMENT	
J45.909	Unspecified asthma uncomplicated		06/17/26	Proventil - Albuterol 90 mcg/actuation Inhl HFAA / Inhale 1 to 2 puffs by mouth as necessary every 4 to 6 hours.	
G47.33	Obstructive sleep apnea (adult) (pediatric)		06/17/26	AS NEEDED FOR SOB	
K21.9	Gastro-esophageal reflux disease without esophagitis		06/17/26	COLACE 100 mg / 1 Capsule by mouth 2 times a day BOWEL REGIMEN	
I44.4	Left anterior fascicular block		06/17/26		
M20.42	Other hammer toe(s) (acquired) left foot		06/17/26		
M21.6X2	Other acquired deformities of left foot		06/17/26		
K64.8	Other hemorrhoids		06/17/26		
E04.1	Nontoxic single thyroid nodule		06/17/26		
E66.9	Obesity unspecified		06/17/26		
Z68.35	Body mass index [BMI] 35.0-35.9 adult		06/17/26		
14. DME and Supplies:				15. Safety Measures:	
walker, cane, ELEVATED TOILET SEAT				seizure precautions, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, hip precautions, anticoagulant precautions	
16. Nutrition:				17. Allergies:	
cardiac diet, diabetic,				bactrim nsais lisinopril verapamil penicillin	
18.A. Functional Limitations				18.B. Activities Permitted	
Endurance				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: Yes					
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: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.				family/caregiver will be responsible for managing treatment patient 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 <div>The patient is a 73-year-old female referred for skilled home health services following a right total hip replacement (THR) Requiring Homecare:performed one day ago secondary to advanced osteoarthritis. Her past medical history is significant for asthma, obstructive sleep apnea managed with CPAP, hypertension, hyperlipidemia, pulmonary embolism, gastroesophageal reflux disease (GERD), type 2 diabetes mellitus, obesity, chronic kidney disease (CKD) stage IIIA, unsteady gait, lumbar radiculopathy, seasonal allergies, left carpal tunnel syndrome, and osteoarthritis involving both knees and hips. The patient resides with her spouse, who is available and assists with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed during her postoperative recovery. Skilled nursing services have been ordered at a frequency of one visit 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 demonstrated appropriate responsiveness throughout the visit. She reported right hip pain rated at 5/10 but stated that her prescribed pain medication regimen has been effective in managing her discomfort. The patient denied shortness of breath, and respiratory assessment revealed clear lung sounds throughout all fields without signs of respiratory distress. Appetite was reported as fair. The patient stated that her last bowel movement occurred prior to surgery, and ongoing monitoring of bowel function was discussed due to the potential effects of postoperative immobility and pain medications. Examination of the surgical site revealed the right hip dressing to be clean, dry, intact, and without visible signs of drainage or postoperative complications. The patient is currently utilizing a walker for all ambulation and mobility activities to promote safety and reduce fall risk during recovery. Medication reconciliation and review were completed during the visit. Skilled nursing education focused on effective pain management strategies,					
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 06/17/2026					
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				F2F date : 06/04/2026	
8028 Ritchie Hwy					
Pasadena, MD 21122					
PHONE: 410-737-5600 FAX: 14107375391 NPI: 1154567709					
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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including adherence to prescribed medications, use of non-pharmacological comfort measures, recognition of medication side effects, and the importance of reporting uncontrolled pain. Postoperative teaching was also provided regarding activity restrictions, incision and dressing care, infection prevention, fall prevention measures, safe use of assistive devices, and signs and symptoms that should be promptly reported to the physician, including increased pain, redness, swelling, drainage, fever, or respiratory concerns. The patient verbalized understanding of all instructions provided. Physical therapy evaluation identified postoperative impairments including right lower extremity weakness, pain, impaired balance, altered gait mechanics, and decreased overall functional mobility. These deficits contribute to difficulty with bed mobility, sit-to-stand transfers, household ambulation, and stair negotiation, significantly impacting the patient's ability to safely perform daily activities independently. Given her multiple comorbidities, history of unsteady gait, and current postoperative status, the patient remains at increased risk for falls, functional decline, and potential rehospitalization. Skilled home health physical therapy is medically necessary to provide gait training, transfer training, therapeutic exercise, balance interventions, fall prevention education, and ongoing patient and caregiver instruction aimed at improving strength, mobility, endurance, and safety. The overall plan of care is focused on promoting safe postoperative recovery, maximizing functional independence, reducing the risk of complications, and facilitating the patient's return to her highest attainable level of function within the home environment.

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 Right 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: eval

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:Yes

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, limited range of motion, limited strength, limited endurance, balance deficit, Pain Interference with ADLs, #1 - Other - Other - RIGHT HIP -

PROCEDURES: physician-ordered wound care: #1 - Other - Other - RIGHT HIP -: SN TO REMOVE RIGHT HIP DRESSING 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

SN Goals

PATIENT-STATED GOAL: I WANT TO WALK BETTER WITHOUT PAIN

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

- * 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

- * 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 self-administers medications as prescribed

- * recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

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

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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, meal preparation is available to patient for all meals					
PT Careplans			PT Goals		
PT WK1: 2 (06/17/26-06/20/26) ,WK2: 2 (06/21/26-06/27/26) ,WK3: 2 (06/28/26-07/04/26)			PATIENT-STATED GOAL: to have a successful post surgical outcome		
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, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, 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, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand			GOALS		
PROCEDURES: B LE mm strengthening: 1, home exercise program: 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 maintaining THR precautions, gait training/stair training, transfers training			Chair to Bed to Chair - 06. Independent		
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 - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car 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, 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			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 - 06. Independent		
			Car 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		
			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 - 06. Independent		
			Lower Body Dressing - 06. Independent		
			Don/Doff Footwear - 06. Independent		
			Eating - 06. Independent		
			Upper Body Dressing - 06. Independent		

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