

Home Health Certification and Plan of Care				Order ID: 1150/19995	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
64102436		06/23/2026		From: 06/23/2026 To: 08/21/2026	
4. Medical Record No.		5. Provider No.			
26488		217058			
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Oscar Snow 1903 Linden Ave, BALTIMORE, MD 21217- 667-228-8455			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB 03/28/1968 9.Sex Male			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
11. ICD Principal Diagnosis Date			CARDURA 1 mg / 1 Tablet by mouth daily at bedtime		
Z47.1 Aftercare following joint replacement surgery 06/23/26			DRISDOL 1,250 mcg (50,000 unit) / 1 Capsule by mouth every 7 days		
13. ICD Other Pertinent Diagnoses Date			NORVASC 10 mg / 1 Tablet by mouth daily		
Z96.641 Presence of right artificial hip joint 06/23/26			GLUCOTROL 10 mg / 1 Tablet by mouth 2 times a day 30 minutes before meals		
I12.9 Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny 06/23/26			HYZAAR 100-25 MG / 1 Tablet by mouth daily		
E11.22 Type 2 diabetes mellitus w diabetic chronic kidney disease 06/23/26			GLUCOPHAGE 500 mg / 1 Tablet by mouth 2 times a day with meals for diabetes		
N18.32 Chronic kidney disease stage 3b 06/23/26			REVATIO 20 mg/tablet / Take 5 tablets by mouth as necessary 1 hour before sexual activity. Do not exceed 1 dose (5 tablets) in 24 hours		
E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy 06/23/26			LIPITOR 80 MG / 1 Tablet by mouth every evening		
G47.33 Obstructive sleep apnea (adult) (pediatric) 06/23/26			Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin:		
Z79.4 Long term (current) use of insulin 06/23/26			Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide:		
Z79.84 Long term (current) use of oral hypoglycemic drugs 06/23/26			Pyridox 50 mcg (2,000 unit) / Take 2,000 Units by mouth once a day		
Z79.82 Long term (current) use of aspirin 06/23/26			ASPIRIN ADULT LOW DOSE 81 mg / 1 Tablet by mouth once a day		
			Flomax - Tamsulosin Hydrochloride 0.4 mg 2 tablets by mouth at bedtime		
			Bladder		
			insulin glargine-yfgn (SEMGLEE) 100 unit/mL / Inject 24 Units subcutaneous once a day This replaces Humulin		
			Aristocort - Triamcinolone 0.1 % Top Oint / Apply to affected area(s) topical twice a day		
14. DME and Supplies:			15. Safety Measures:		
wound care supplies, commode, grab bars, walker, urinary/catheter supplies, hand held shower, rolling walker, diabetic supplies, cane, 4 wheeled walker			walker precautions, smoke detectors , medication safety, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, transfer with assist, supervision at all times, sharps precautions, ambulates with assistance, hip precautions, , standard precautions, hand rails, cardiac precautions, bathroom safety, activity supervision		
16. Nutrition:			17. Allergies:		
diabetic			flulaval		
18.A. Functional Limitations			18.B. Activities Permitted		
Ambulation, Bowel/Bladder Incontinence, Endurance			Walker, Exercises Prescribed, 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:			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: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.			SN and OT: family/caregiver will be responsible for managing treatment PT: pat		
Homebound status: After undergoing Right Total Hip Replacement surgery, 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: <p class="15">The patient is a 58-year-old male admitted to home health services following hospitalization for severe right hip osteoarthritis, status post right total hip arthroplasty on 06/18/2026, complicated by postoperative hypotension secondary to acute blood loss anemia requiring transfusion of one unit of packed red blood cells, as well as urinary retention requiring placement of a 16 Fr Foley catheter with a leg bag during the day and a drainage bag at night. His past medical history is significant for diabetes mellitus, hypertension, chronic kidney disease, obstructive sleep apnea, benign prostatic hyperplasia, and severe osteoarthritis. On skilled nursing assessment, the patient was alert and oriented with stable vital signs, denied dizziness, chest pain, or shortness of breath, and reported swelling at the right hip surgical site. The surgical incision was clean, dry, intact, and free of drainage or signs of infection, with pain adequately managed by prescribed medications. The patient ambulates with a rolling walker and requires assistance with mobility, transfers, and lower-body dressing due to postoperative weakness, edema, pain, limited range of motion, and fall risk. Physical therapy evaluation revealed decreased right lower extremity strength (2-/5) secondary to edema, and the patient was instructed in a home exercise program, edema management, and safety precautions. Occupational therapy noted the patient was independent with grooming and upper-body dressing but required minimal to moderate assistance for lower-body dressing and standby assistance for transfers. During the PT visit, the patient reported burning pain and leakage from the Foley catheter, limiting participation in therapy, and was advised to seek urgent evaluation. Skilled nursing will continue to provide cardiopulmonary assessment, postoperative monitoring, incision and catheter assessment, pain and medication management, diabetes education, monitoring for anemia, bleeding, infection, and hemodynamic instability, as well as fall prevention and patient/caregiver education to promote recovery and a safe return to prior level of function.<o:p></o:p></p><p class="15"> </p><p class="15">Date of Order<o:p></o:p></p><p class="15"><span					
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 06/23/2026					
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.		
Christelle Nong Libend 1701 Twin Springs Road Halethorpe, MD 21227 PHONE: FAX: NPI: 1780096446			F2F date : 06/21/2026		
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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style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman'; font-size:11.0000pt;mso-font-kerning:1.0000pt;">061232026
Physician Face-to-Face Date: 06/21/2026Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management PT-eval & treat OT-eval & treat DX: Right Total Hip Replacement surgeryHomebound 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:PTEval Notes:OT Eval Notes:Physician: Nong Libend, Christelle</p></div></div><div data-bbox=

SN Careplans

SN WK1: 1 (06/23/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26) ,WK3: 1 (07/05/26-07/11/26)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

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; 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.

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition hydration · Pain: Pain management measures: pain medication, rest, body alignment ROM

SN Goals

PATIENT-STATED GOAL: Patient states he wants to be able to walk up and down the stairs again.

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

- * urinary catheter management including how to flush catheter
- * change and wash drainage bags
- * prevent infection including proper handwashing
- * positioning of catheter
- * 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

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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nutrition, hydration ; and pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds Advance Directive:POLST (Physician Orders for Life-Sustaining Treatment) PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, dependent edema, urine retention, M1610 - Urinary Catheter, muscle weakness, swelling of affected area, limited endurance, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, Pain Interference with Therapy activities, balance deficit, loss of appetite, #1 - Non-Observable Surgical Wound - Other - Right Hip - PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Right Hip -: 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., cough/deep breathing exercises, incentive spirometer, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration 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, * urinary catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, 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, caregiver administers and/or packages medications appropriately	
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PT Careplans PT WK1: 2 (06/23/26-06/27/26) ,WK2: 2 (06/28/26-07/04/26) ,WK3: 1 (07/05/26-07/11/26) PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: seated knee ext, hip flex, 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. Upgrade as tolerated, equipment training, work simplification/energy conservation, gait training/stair training, transfers training TEACH PATIENT/CAREGIVER: 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 - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance	PT Goals PATIENT-STATED GOAL: To be able to walk without pain GOALS 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 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 - 05. Setup or clean-up 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 Walk 10 Feet - 04. Supervision or touching assistance Shower/Bathe Self - 02. Substantial/maximal assistance Upper Body Dressing - 05. Setup or clean-up assistance
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OT Careplans	OT Goals
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OT WK1: 1 (06/23/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, 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, equipment training, transfers training: Sit to stand and toilet transfer 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 - 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			PATIENT-STATED GOAL: To put has pants on independently 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 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	

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