Home Health Certification and Plan of Care

Order ID: 1150/20065

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
881051818	06/10/2026	From: 06/10/2026 To: 08/08/2026	26128	217058

6. Patient's Name and Address

Brenda Worthy
519 Bond Ave,
REISTERSTOWN, MD 21136-
202-355-4075

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 06/02/1943 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	06/10/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	06/10/26
M16.12	Unilateral primary osteoarthritis left hip	06/10/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	06/10/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	06/10/26
N18.31	Chronic kidney disease stage 3a	06/10/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	06/10/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	06/10/26
E11.69	Type 2 diabetes mellitus with other specified complication	06/10/26
E78.5	Hyperlipidemia unspecified	06/10/26
I70.0	Atherosclerosis of aorta	06/10/26
J96.11	Chronic respiratory failure with hypoxia	06/10/26
I27.20	Pulmonary hypertension unspecified	06/10/26
M35.89	Other specified systemic involvement of connective tissue	06/10/26
E04.1	Nontoxic single thyroid nodule	06/10/26
J30.9	Allergic rhinitis unspecified	06/10/26
H04.123	Dry eye syndrome of bilateral lacrimal glands	06/10/26
J84.9	Interstitial pulmonary disease unspecified	06/10/26
E27.9	Disorder of adrenal gland unspecified	06/10/26
N28.1	Cyst of kidney acquired	06/10/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	06/10/26
Z90.710	Acquired absence of both cervix and uterus	06/10/26
Z90.722	Acquired absence of ovaries bilateral	06/10/26
Z86.0100	Personal history of colonic polyps	06/10/26
Z87.891	Personal history of nicotine dependence	06/10/26

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

XALATAN 0.005 % Opht Drop / Instill 1 drop both eyes in the evening
Acetaminophen - Acetaminophen 650 mg 1 tablet by mouth every 6 hours
Ascorbic Acid (VITAMIN C WITH ROSE HIPS) 1,000 mg by mouth once a day
Eliquis - Apixaban 2.5mg by mouth twice a day
LIPITOR 40 mg / 1 Tablet by mouth daily for cholesterol
Cardizem Cd - Diltiazem Hydrochloride SR 120 mg / 1 Capsule by mouth daily High blood pressure
CELLCEPT 500 mg/tablet / Take 2 tablets by mouth twice daily Immune system
Cholecalciferol, Vitamin D3, (D3 2000) 50 mcg (2,000 unit) capsule / Take 2,000 units by mouth once a day (Patient taking differently: Take 1,000 Units by mouth daily)
COZAAR 25 mg/tablet / Take 2 tablets by mouth daily Blood pressure
Esidrix - Hydrochlorothiazide 25 mg/tablet / Take half tablet by mouth once a day
IMODIUM 2 MG capsule by mouth as needed for diarrhea
REVATIO 20 mg/tablet / Take 2 tablets by mouth 3 times a day
Vitamin B-12 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1,000 mcg / 1 Tablet by mouth once a day
Oxygen - Oxygen 2Liters/NC nasal cannula as necessary

14. DME and Supplies:

oxygen supplies, rolling walker, , bath bench

15. Safety Measures:

anticoagulant precautions, hip precautions, walker precautions, medication safety, fall precautions, diabetic precautions, ambulates with device

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

lisinopril naproxen pcn

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

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: fair

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

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

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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/10/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Michael Nzeogu
1920 Ballenger Ave
Alexandria, VA 22314
PHONE: 301-618-5500 FAX: NPI: 1336520345

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 : 05/29/2026

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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Clinical Condition Requiring Homecare:

The patient is an 83-year-old female admitted to home health following a right total hip arthroplasty. Her past medical history is significant for arteriosclerotic cardiovascular disease (ASCVD), end-stage right hip osteoarthritis, type 2 diabetes mellitus, chronic kidney disease stage III, interstitial lung disease, chronic hypoxemic respiratory failure, obstructive sleep apnea (OSA), pulmonary hypertension, hypertension, coronary artery disease (CAD), antisynthetase syndrome, balance impairment, and other comorbidities. Upon arrival, the patient was alert and oriented 4, resting in bed, and denied pain, reporting adequate relief with tramadol. She denied shortness of breath, chest pain, or dizziness and reported intermittent use of oxygen via nasal cannula at 2 L/min. Assessment revealed lungs clear to auscultation, audible bowel sounds with the last bowel movement reported the previous day, palpable pulses, no edema, bilateral knee-high compression stockings in place, and a surgical incision that was clean, dry, and intact. Vital signs were within normal limits, medications were reviewed, and the patient was admitted to home health services. Physical therapy evaluation demonstrated bilateral lower extremity weakness, impaired balance, pain-limited mobility, and altered gait mechanics, resulting in difficulty with bed mobility, transfers, household ambulation, and stair negotiation, requiring an assistive device and caregiver assistance for safety. The patient would benefit from continued skilled home health physical therapy to address strengthening, balance, gait and transfer training, endurance, pain management, and fall prevention to maximize functional independence, promote safe postoperative recovery, and reduce the risk of further functional decline and hospitalization.<o:p></o:p>   Date of Order<o:p></o:p> 06/10/2026
Physician Face-to-Face Date: 05/29/2026<o:p></o:p> Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Hip Replacement surgery<o:p></o:p> Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
1 - SOC - SN Notes:<o:p></o:p> PT Eval Notes: <o:p></o:p> Physician: Nzeogu, Michael

SN Careplans

SN WK1: 1 (06/10/26-06/13/26) ,WK2: 1 (06/14/26-06/20/26)

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; 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

SN Goals

PATIENT-STATED GOAL: I want to be as independent as I can.

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/10/2026

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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, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:Yes

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1400 - Dyspnea, muscle weakness, limited strength, balance deficit, Pain Interference with ADLs, bruising/discoloration, #1 - Non-Observable Surgical Wound - Anterior Right Abdomen -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Abdomen -, 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, * 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

PT Careplans

PT WK1: 2 (06/10/26-06/13/26) ,WK2: 3 (06/14/26-06/20/26) ,WK3: 1 (06/21/26-06/27/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170O1 - 12 Steps, GG0130F1 - Upper Body Dressing, 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, GG0170D1 - Sit to Stand, 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

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 improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 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, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: to have a successful post surgical outcome

GOALS
Chair to Bed to Chair - 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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Oral Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

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

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/10/2026