Home Health Certification and Plan of Care

Order ID: 1150/20532

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
37233298	07/14/2026	From: 07/14/2026 To: 09/11/2026	14005	217058

6. Patient's Name and Address

Joseph Larue
7835 Falling Leaves Ct,
ELLICOTT CITY, MD 21043-
240-381-5243

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 07/02/1953 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	07/14/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	07/14/26
M17.0	Bilateral primary osteoarthritis of knee	07/14/26
H90.3	Sensorineural hearing loss bilateral	07/14/26
G50.8	Other disorders of trigeminal nerve	07/14/26
G25.0	Essential tremor	07/14/26
G56.02	Carpal tunnel syndrome left upper limb	07/14/26
M47.22	Other spondylosis with radiculopathy cervical region	07/14/26
G60.9	Hereditary and idiopathic neuropathy unspecified	07/14/26
H04.123	Dry eye syndrome of bilateral lacrimal glands	07/14/26
Z79.82	Long term (current) use of aspirin	07/14/26
Z87.891	Personal history of nicotine dependence	07/14/26
Z85.818	Prsnl hx of malig neoplm of site of lip oral cav & pharynx	07/14/26
Z85.828	Personal history of other malignant neoplasm of skin	07/14/26

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

Protonix - Pantoprazole Sodium 20 mg, Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day 30 to 60 minutes before breakfast and dinner
Patient states- taking as needed for heartburn.
Tylenol - Acetaminophen 500 mg, Take 2 tablets by mouth every 6 hours Take 2 tablets by mouth every 6 hours for 72 hours
Patient states as needed for pain to incision in right hip.
Neurontin - Gabapentin 300 mg, Take 2 capsules by mouth three times a day Take 3 capsules by mouth every morning, 2 capsules in the afternoon, and 3 capsules before bedtime
Patient states to treat neuropathy.
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg by mouth every 4 hours As needed for incision pain, per patient.
Aspirin - Aspirin 81mg by mouth once a day
Colace - Docusate Sodium 100mg by mouth twice a day To assist with having a bowel movement per patient.
Xanax - Alprazolam 0.25 mg, Take one-half tablet by mouth at bedtime Take one-half tablet by mouth at bedtime as needed for sleep, per patient.

14. DME and Supplies:

walker, cane

15. Safety Measures:

standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, emergency phone # clearly displayed, hip precautions, anticoagulant precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

ceftin

18.A. Functional Limitations

Ambulation, Endurance

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: 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: 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: After undergoing Left 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 71-year-old male admitted to home health services following a left hip replacement. His past medical history is significant for left hip osteoarthritis, left trigeminal neuropathy, metastatic cancer, bilateral knee osteoarthritis, idiopathic peripheral neuropathy, mixed connective tissue disease, cervical spondylosis with radiculopathy, essential tremor, and a history of oropharyngeal squamous cell carcinoma. The patient resides with his spouse, who provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. Skilled nursing services have been ordered at a frequency of once weekly for two weeks, and a physical therapy evaluation has been ordered to address postoperative functional deficits. The patient is alert and oriented 3, pleasant, and able to communicate his needs appropriately. He reports minimal postoperative pain and denies shortness of breath. Lung sounds are clear throughout all lung fields, appetite is good, and his last bowel movement occurred today. The left anterior hip surgical dressing was assessed and remains clean, dry, and intact with no reported concerns. The patient ambulates with a walker for safe mobility due to postoperative weakness and impaired balance. A comprehensive medication review and reconciliation were completed. Skilled nursing provided education regarding medication adherence, postoperative hip replacement care, effective pain management techniques, and reinforcement of prescribed hip precautions. Additional education included safe walker use, fall prevention strategies, activity modification, and the importance of reporting increased pain, redness, swelling, drainage, fever, or any other signs of surgical site infection. The patient verbalized understanding of all education provided. Physical therapy evaluation identified postoperative lower extremity weakness, decreased hip range of motion, impaired balance, antalgic gait, and reduced functional mobility requiring the use of a front-wheeled walker for safe ambulation. These deficits significantly limit the patient's functional independence and increase his risk for falls. Skilled home health physical therapy is medically

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/14/2026

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 : 06/29/2026

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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necessary to provide gait training, transfer training, therapeutic exercises, balance training, reinforcement of hip precautions, fall prevention education, and progressive functional mobility training to improve strength, restore mobility, and maximize safe independence in the home. Continued skilled nursing services remain medically necessary for ongoing postoperative assessment, surgical site monitoring, medication management, pain management, patient education, and coordination of care to promote healing and prevent complications.
 Date of Order 07/14/2026 Orders Physician Face-to-Face Date: 06/29/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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
 Physician Huang, James

SN Careplans

SN WK1: 1 (07/14/26-07/18/26) ,WK2: 1 (07/19/26-07/25/26)

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 ANTERIOR HIP
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited endurance, limited strength, limited range of motion, swelling of affected area, balance deficit, Pain Interference with ADLs, bruising/discoloration, #1 - Non-Observable Surgical Wound - Anterior Left Hip - LEFT ANTERIOR HIP DRESSING INTACT

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Hip - LEFT ANTERIOR HIP DRESSING INTACT: SN /PT TO REMOVE LEFT 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, * 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

SN Goals

PATIENT-STATED GOAL: TO WALK BETTER WITHOUT PAIN

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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/14/2026

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medication(s) purpose, schedule, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 2 (07/14/26-07/18/26) ,WK2: 3 (07/19/26-07/25/26) ,WK3: 1 (07/26/26-08/01/26)

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., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, 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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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