Home Health Certification and Plan of Care

Order ID: 1150/19835

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
51194775	05/13/2026	From: 05/13/2026 To: 07/11/2026	18673	217058

6. Patient's Name and Address

George Devoe Jr
2410 Chestnut Terrace Ct,
ODENTON, MD 21113-
585-313-8846

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 11/01/1946 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	05/13/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	05/13/26
I48.91	Unspecified atrial fibrillation	05/13/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	05/13/26
N18.31	Chronic kidney disease stage 3a	05/13/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/13/26
J45.909	Unspecified asthma uncomplicated	05/13/26
I71.21	Aneurysm of the ascending aorta without rupture	05/13/26
I44.0	Atrioventricular block first degree	05/13/26
K31.A0	Gastric intestinal metaplasia unspecified	05/13/26
I34.0	Nonrheumatic mitral (valve) insufficiency	05/13/26
F41.9	Anxiety disorder unspecified	05/13/26
J31.0	Chronic rhinitis	05/13/26
E78.5	Hyperlipidemia unspecified	05/13/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/13/26
M10.9	Gout unspecified	05/13/26
E55.9	Vitamin D deficiency unspecified	05/13/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	05/13/26
Z79.01	Long term (current) use of anticoagulants	05/13/26
Z86.0100	Personal history of colonic polyps	05/13/26
Z87.891	Personal history of nicotine dependence	05/13/26

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

Singulair - Montelukast Sodium 10 mg, take 1 tablet by mouth in the evening Take 1 tablet by mouth every evening
Aldactone - Spironolactone 25 mg, take 1 tablet by mouth once a day Take 1 tablet by mouth daily
Mycobutin - Rifabutin 150 mg, take 1 capsule by mouth twice a day Take 1 capsule by mouth 2 times a day for 14 days. Avoid grapefruit products with this medicine. (Treatment with amoxicillin, OTC omeprazole)
Omeprazole Magnesium - Omeprazole Magnesium 20 mg , take 1 capsule by mouth twice a day Take 1 capsule by mouth 2 times a day 30 minutes to 1 hour prior to breakfast and dinner for 14 days
Drisdol - Ergocalciferol 1,250 mcg (50,000 unit), take 1 capsule by mouth as necessary Take 1 capsule by mouth every 7 days
Pantoprazole - Pantoprazole Sodium 40 mg, take 1 tablet by mouth twice a day take 1 tablet by mouth 2 times a day
Eliquis - Apixaban 5 mg, take 1 tablet by mouth twice a day Take 1 Tablet (5 mg total) by mouth 2 times daily
Lipitor - Atorvastatin Calcium 40 mg, take 1 tablet by mouth once a day Take 1 tablet by mouth daily
Cozaar - Losartan Potassium 50 mg, take 1 tablet by mouth once a day Take 1 tablet by mouth daily
Fenofibrate - Fenofibrate 160 mg, take 1 tablet by mouth once a day Take 1 tablet by mouth daily
Tylenol - Acetaminophen 325 mg , take 1 tablet by mouth every 4 hours Take 1 tablet by mouth every 4 hours as needed for pain
Oxaydo - Oxycodone Hydrochloride 5mg by mouth every 6 hours
Verapamil - Verapamil Hydrochloride 20 mg, take 1 tablet by mouth three times a day Take 1 tablet by mouth daily At 10pm
Zoloft - Sertraline Hydrochloride 25 mg, take 1 tablet by mouth once a day Take 1 tablet

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/13/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Victoria Clark
1221 Mercantile Ln
Largo, MD 20774
PHONE: 301-618-5500 FAX: NPI: 1619362183

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 : 05/01/2026

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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by mouth
daily
Zetia - Ezetimibe 10 mg, take 1 tablet by mouth once a day Take 1 tablet
by mouth
daily
Budesonide Formoterol 80-4.5 mcg, Inhale 2 Puffs inhalant twice a day
Inhale 2 Puffs
by mouth 2
times a day
Per Dr. Len
Fluticasone - Fluticasone Furoate 50 mcg, Use 1 Spray nasal once a day Use
1 Spray
in each nostril
daily
Astelin - Azelastine Hydrochloride 137 mcg (0.1 %) Nasl Spray, use 1 spray
nasal twice a day Use 1 Spray
in each nostril
2 times a day
Debrox - Debrox 6.5 % Otic Drop, Instill 5 Drops into affected ear otic twice
a day Instill 5 Drops
into affected
ear(s) 2 times
a day
Clonidine - Clonidine 0.1 mg/24 hr TD Weekly Patch, apply 1 patch topical
once a week Apply 1 Patch
to skin every
7 days

14. DME and Supplies:	15. Safety Measures:
bath bench, cane, rolling walker	no bending, fall precautions, standard precautions, transfer with assist, walker precautions, hip precautions, anticoagulant precautions, ambulates with assistance
16. Nutrition:	**17. Allergies:**
Z. NO PHYSICIAN-ORDERED DIET	asprin lovastatin
18.A. Functional Limitations	**18.B. Activities Permitted**
Ambulation,	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:	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.	family/caregiver will be responsible for managing treatment

Homebound status: After undergoing Total right 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 79-year-old male with past medical history significant for bilateral hip joint disease status post posterior total hip replacement (left hip THR on 11/10/25 and right hip THR on 5/11/26). Patient was seen at home postoperatively and was alert and oriented 3, resting comfortably in a recliner on arrival with wife and son present and actively involved in care. Patient reports incisional/surgical site pain rated 4/10, currently well controlled with prescribed analgesics, which the patient reports taking as directed. Non-removable surgical dressing remains clean, dry, and intact with planned removal per schedule; ice therapy is being used appropriately to the operative hip. No chest pain or acute cardiopulmonary symptoms reported. Bowel function is intact with reported bowel movement without complication; patient remains on bowel regimen. No peripheral edema noted; bilateral TED stockings in place as ordered. Medications were reviewed with no discrepancies, missing doses, or refill needs identified. Patient is scheduled for surgical follow-up on 6/2/26 and is planned to begin outpatient physical therapy on 5/26/26. Admission documentation was completed with patient agreement to plan of care. On PT evaluation, patient presents with postoperative limitations consistent with recent total hip arthroplasty, including decreased strength, reduced endurance, impaired balance, unsteady gait, difficulty with transfers, impaired bed mobility, and difficulty negotiating stairs, resulting in increased fall risk. Due to functional limitations, patient requires a front-wheeled walker and standby to minimal assistance for safe mobility and is not currently safe for independent community or household ambulation without assistance. Posterior hip precautions were reinforced, including avoidance of hip flexion greater than 90 degrees, avoidance of hip adduction/crossing midline, use of abduction pillow as prescribed, and restriction of active hip abduction until cleared by surgeon. Skilled interventions included instruction in safe transfer techniques with emphasis on proper hand and foot placement, forward weight shift, and controlled eccentric lowering to sitting; patient required SBA to minimal assist. Bed mobility training was provided with cueing for body mechanics, with patient requiring minimal assistance for safe supine-to-sit and repositioning. Gait training was performed on level surfaces with walker, emphasizing upright posture, improved step height and length, and safe positioning within the device; patient ambulated with standby assistance and was advised to use walker at all times. Therapeutic exercise program included supine ankle pumps, quadriceps sets, and gluteal sets (120), and heel slides (110), with home exercise program provided and instructed for completion twice daily. Passive range of motion to the operative hip was performed in supine position within tolerance. Patient was educated on the importance of early, frequent ambulation to promote circulation and reduce postoperative complications, with recommendation for short household walks every 1-2 hours as tolerated, progressing gradually in duration. Patient and caregiver were educated on edema management strategies including elevation of lower extremities above heart level during rest and use of compression garments if prescribed, as well as comprehensive fall prevention strategies and home safety measures. Education was also provided regarding signs and symptoms of wound infection (fever, chills, increased redness, swelling, pain, drainage, or wound changes) and when to seek medical attention. Pain management education included instruction to take medication at onset of pain, monitor for side effects such as dizziness and constipation, and to take analgesics approximately one hour prior to therapy sessions to

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/13/2026

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optimize participation. Plan of care was discussed with patient and caregivers, and agreement was confirmed. Patient will continue to receive skilled home health physical therapy services to address strength, mobility, balance, gait, transfers, stair negotiation, and safety awareness, with progression toward functional independence and reduced fall risk. Without continued skilled intervention, patient remains at risk for further functional decline, falls, and loss of independence.
 Date of Order 05/13/2026 Orders Physician Face-to-Face Date: 05/01/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control, PT-eval & treat due to Total right 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 Clark, Victoria

SN Careplans

SN WK1: 1 (05/13/26-05/16/26) ,WK2: 1 (05/17/26-05/23/26)

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.
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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, swelling of affected area, limited range of motion, limited endurance, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, loss of appetite

PROCEDURES: cough/deep breathing exercises, physician-ordered wound care: 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.

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

SN Goals

PATIENT-STATED GOAL: Be able to attend outpatient therapy

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

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

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PT WK1: 3 (05/13/26-05/16/26) ,WK2: 3 (05/17/26-05/23/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, Pain Effect on Sleep, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper 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, hip flex, 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., gait training/stair training, transfers training

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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 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, 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 - 04. Supervision or touching 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, Eating - 06. Independent

PATIENT-STATED GOAL: I want to get back to walking and line dancing

GOALS
Toilet Transfer - 06. Independent

Sit to Stand - 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

Eating - 06. Independent

Chair to Bed to Chair - 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

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Upper Body Dressing - 05. Setup or clean-up assistance

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

Car Transfer - 05. Setup or clean-up assistance

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/13/2026