Home Health Certification and Plan of Care

Order ID: 1150/20622

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
11235066	07/17/2026	From: 07/17/2026 To: 09/14/2026	27554	217058

6. Patient's Name and Address

Rose Stevens
7 Lona Ct,
NOTTINGHAM, MD 21236-
410-245-9050

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 01/14/1955 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	07/17/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	07/17/26
E78.5	Hyperlipidemia unspecified	07/17/26
I70.0	Atherosclerosis of aorta	07/17/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	07/17/26
N18.31	Chronic kidney disease stage 3a	07/17/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/17/26
M51.16	Intervertebral disc disorders w radiculopathy lumbar region	07/17/26
E03.9	Hypothyroidism unspecified	07/17/26
H25.093	Other age-related incipient cataract bilateral	07/17/26
H04.123	Dry eye syndrome of bilateral lacrimal glands	07/17/26
H81.10	Benign paroxysmal vertigo unspecified ear	07/17/26
Z87.891	Personal history of nicotine dependence	07/17/26
Z79.82	Long term (current) use of aspirin	07/17/26
Z79.891	Long term (current) use of opiate analgesic	07/17/26
Z79.890	Hormone replacement therapy	07/17/26
Z98.1	Arthrodesis status	07/17/26

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

NORVASC 5 MG / 1 Tablet by mouth daily HTN
Synthroid - Levothyroxine Sodium 112 MCG / 1 Tablet by mouth once a day Need labs
PROTONIX DR 40 MG / 1 Tablet by mouth in the morning 30 minutes before a meal
ECOTRIN 0 DR 81 MG / 1 Tablet by mouth 2 times a day
COLACE 100 MG / 1 Capsule by mouth 2 times a day
Ezetimibe - Ezetimibe 10 mg Take 1 tablet by mouth once a day
Gabapentin - Gabapentin 300 mg take 1 capsule by mouth twice a day

14. DME and Supplies:

walker, bath bench

15. Safety Measures:

walker precautions, standard precautions, , medication safety, fall precautions, hip precautions, bathroom safety, ambulates with device

16. Nutrition:

low sodium

17. Allergies:

no known allergies

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: Good

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.

Clinical Condition Requiring Homecare:

<p class="15">The patient is a 71-year-old female admitted to home health services following an elective right total hip replacement, returning home the same day with family assistance. Her past medical history is significant for hypertension, hyperlipidemia, gastroesophageal reflux disease, hypothyroidism, chronic kidney disease stage 3, and atherosclerosis of the aorta. She resides with her husband, who serves as her primary caregiver, and currently ambulates with a walker. On assessment, the surgical incision was covered with a Mepilex dressing with physician orders to remove it on postoperative day seven and leave the incision open to air unless drainage occurs, in which case a dry dressing should be applied. The patient presents with postoperative pain, decreased right lower extremity strength and range of motion, impaired balance, gait dysfunction, and deficits in bed mobility and transfers, requiring assistance with all mobility and placing her at high risk for falls, making her homebound due to the considerable effort required to leave the home. Skilled nursing provided education regarding medication adherence, pain management, constipation prevention, personal hygiene, signs and symptoms of infection, edema management, lower extremity positioning, and postoperative precautions. During the visit, it was noted that the patient was wearing compression stockings but had not received instructions regarding cryotherapy; the nurse contacted the surgeon's office and was advised to instruct the patient to apply ice to the surgical site for 20 minutes on and 20 minutes off. The patient has an ice pack available from a previous surgery and verbalized understanding of these instructions. Physical therapy initiated a home exercise program consisting of ankle pumps, quad sets, heel slides, gluteal sets, seated long arc quadriceps exercises, and standing marching, with instruction on stair negotiation using a handrail and single-point cane, proper rolling walker sequencing, frequent ankle pumps for edema prevention, and removal of area rugs to reduce fall risk. A written home exercise program was provided, and the patient demonstrated understanding. Continued skilled nursing and physical therapy are medically necessary to monitor postoperative recovery, manage pain, improve strength, balance, mobility, and safety, and restore the patient to her prior level of independence while reducing the risk of complications and falls.<span

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/17/2026

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 : 06/24/2026

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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Rose Stevens 7 Lona Ct, NOTTINGHAM, MD 21236- 410-245-9050	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

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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;">Clinical Condition Requiring
Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Hip Replacement surgery<span
style="mso-spacerun:'yes';font-family:Calibri;mso-bidi-font-family:'Times New Roman';
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Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<span
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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;">Huang, James

SN Careplans

SN WK1: 1 (07/17/26-07/18/26) ,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

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

SN Goals

PATIENT-STATED GOAL: To walk 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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/17/2026

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Advance Directive:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, balance deficit, Pain Interference with ADLs, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Hip - Right hip surgical site

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Hip - Right hip surgical site: Right hip surgical site: Remove mepilex dressing on the 7th day post op and LOTA. If drainage occurs, cover with dry dressing., 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 medication(s) purpose, schedule

PT Careplans

PT WK1: 1 (07/17/26-07/18/26) ,WK2: 3 (07/19/26-07/25/26) ,WK3: 2 (07/26/26-08/01/26)

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, 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

PROCEDURES: Medication management : Reviewed medication with pt, incentive spirometer, home exercise program: Supine qs, aps, Heelslides, seated laq, GS, standing rle hip flexion to 45 degrees, hamstring curls, equipment training, work simplification/energy conservation, gait training on uneven surfaces, 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 - 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 - 03. Partial/moderate assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent

PT Goals

PATIENT-STATED GOAL: To walk with no device and being independent in the home

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

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

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

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

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

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/17/2026