Home Health Certification and Plan of Care

Order ID: 1150/21276

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
111053730	08/11/2026	From: 08/11/2026 To: 10/09/2026	26273	217058

6. Patient's Name and Address

Mitchell Miller
484 Bruce Ave,
Odenton, MD 21113-
410-340-6427

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 04/25/1970 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	08/11/26

13. ICD	Other Pertinent Diagnoses	Date
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	08/11/26
M10.9	Gout unspecified	08/11/26
E78.5	Hyperlipidemia unspecified	08/11/26
D44.5	Neoplasm of uncertain behavior of pineal gland	08/11/26
N52.8	Other male erectile dysfunction	08/11/26
E66.01	Morbid (severe) obesity due to excess calories	08/11/26
Z68.36	Body mass index [BMI] 36.0-36.9 adult	08/11/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	08/11/26
Z79.4	Long term (current) use of insulin	08/11/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	08/11/26
Z79.82	Long term (current) use of aspirin	08/11/26
Z96.643	Presence of artificial hip joint bilateral	08/11/26

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

CYMBALTA SR 30 mg/capsule / Take 1 to 2 capsules by mouth once a day
PEPCID 20 mg / 1 Tablet by mouth 2 times a day
PROTONIX Delayed Release 20 mg / 1 Tablet by mouth daily 30 to 60 minutes prior to a meal
Zestril - Lisinopril 10 mg / 1 Tablet by mouth daily for kidney and heart protection
ZOCOR 40 mg / 1 Tablet by mouth every evening for heart and stroke protection
GLUCOPHAGE 1,000 mg / 1 Tablet by mouth 2 times a day with meals
GLUCOTROL 10 mg / 1 Tablet by mouth in the morning before breakfast and take 1 tablet in the evening before dinner for diabetes.
ADIPEX-P 37.5 mg / 1 Tablet by mouth every morning
NEURONTIN 300 mg/capsule / Take 2 capsules by mouth 3 times a day
ASPIRIN 81 MG ORAL TBEC by mouth one a day with food
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg 1-2 tabs by mouth every 4-6 hours Pain
Colace - Docusate Sodium 100 MG, Give 1 tablet by mouth twice a day Constipation
Extra Strength Tylenol - Acetaminophen 500 mg, Take 2 tablet (1,000 mg total) by mouth as necessary Pain
Gabapentin - Gabapentin 600 mg by mouth three times a day
semaglutide (OZEMPIC) 1 mg/dose (4 mg/3 mL) / Inject 1 mg subcutaneous once a week
insulin glargine-yfgn (SEMGLEE) SubQ Soln 100 unit/mL / Inject 65 Units subcutaneous twice a day
Ozempic 0.5mg subcutaneous once a week Saturday morning

14. DME and Supplies:

wound care supplies, wheelchair, rolling walker, grab bars, hand held shower, diabetic supplies, 4 wheeled walker, bath bench

15. Safety Measures:

wheelchair precautions, walker precautions, medication safety, , infectious material management, hip precautions, fall precautions, diabetic precautions, , bathroom safety, avoid temperature extremes, ambulates with device, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

jardiance meloxicam Pioglitazone Hcl

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Wheelchair, 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: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., 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 Right total 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 56-year-old male who underwent right total hip replacement (THR) on 08/10/2026 and returned home the same day with assistance from his spouse, Sandra, with family available to provide continuous support. The patient is homebound, requiring assistance from another person and an assistive device to safely leave the home. PT evaluation identified right hip pain, decreased right hip strength, impaired functional mobility, difficulty negotiating steps, unsteady gait, impaired transfers and balance, history of falls, decreased safety awareness, and increased fall risk. Skilled home health PT is medically necessary to address these deficits, improve strength, transfers, gait, stair negotiation, balance, safety awareness, and overall functional independence, as the patient remains at risk for falls, further functional decline, and loss of independence without skilled intervention. The patient and primary caregiver participated in development of and agreed with the PT plan of care, with home PT scheduled beginning 08/11/2026 at 3W1, 2W1, and 1W1; follow-up with Dr. Nzeogu is planned for 08/25/2026, with transition to outpatient PT anticipated on 08/26/2026. Posterior hip precautions were reviewed, including avoiding hip flexion greater than 90 degrees, keeping the knees apart and not crossing the legs, avoiding combined hip flexion and internal rotation, and avoiding excessive inward rotation of the operative leg. Education was provided regarding causes and management of edema, including elevating the lower extremities above heart level during rest and using compression garments if recommended by the physician. Signs and symptoms of surgical incision/wound infection were reviewed, including fever, chills, redness, swelling, increased pain, bleeding, drainage, persistent nausea/vomiting, or pain not relieved by medication. The patient was instructed in safe transfers using a walker, including proper hand and foot placement, forward weight shifting, and reaching back for the chair before sitting; he required minimal assistance to standby assistance for safe transfers. Bed mobility training was provided with instruction in proper body mechanics for safely entering and exiting bed, with the patient requiring minimal assistance. Therapeutic exercises were initiated, including ankle pumps, quadriceps sets, and gluteal sets, 1 set of 20 repetitions each, and heel slides, 1 set of 10 repetitions. A written home exercise program was left in the home with instructions to perform exercises twice daily. Passive range of motion of the right hip was performed in the supine position. Gait training was completed on level surfaces using a walker, with standby assistance required and cues provided for proper walker positioning, increased bilateral step height and step length, and overall safety; the patient was advised to use the walker at all times. Education was provided regarding the benefits of daily ambulation for circulation and prevention of complications associated with inactivity, with instructions to take short walks every 1-2 hours and gradually progress walking duration from approximately 3-5 minutes as tolerated. The patient was instructed to apply ice to the right hip for 20 minutes using an appropriate barrier and to perform skin checks every 5 minutes. Pain was reported as well controlled with current medications. Pain-management education included taking medication at the onset of pain, monitoring for dizziness and constipation as potential side effects, and taking prescribed pain medication

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 08/11/2026

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 : 07/31/2026

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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approximately one hour before PT visits as recommended. The patient was instructed to seek emergency medical assistance for chest pain, shortness of breath, or severe/unrelieved pain. The patient verbalized understanding through teach-back.
 Date of Order 08/11/2026 Orders Physician Face-to-Face Date: 07/31/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control, PT-eval & treat due to Right total 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 Nzeogu, Michael

SN Careplans

SN WK1: 1 (08/11/26-08/15/26) ,WK2: 1 (08/16/26-08/22/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 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: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, abn cholesterol > 200 mg/dL, M1400 - Dyspnea, weight gain > 2lb/24 h OR 5lb/1 wk, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, heartburn/indigestion, constipation, muscle weakness, limited endurance, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit, balance deficit, difficulty sleeping, obesity, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Hip -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior 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., cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange resources for vision-impaired

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, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is

SN Goals

PATIENT-STATED GOAL: I want to have my strength back so I can help around the house more

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
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/11/2026

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adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 3 (08/11/26-08/15/26) ,WK2: 2 (08/16/26-08/22/26) ,WK3: 1 (08/23/26-08/29/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface, 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, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide Seated-LAQ, 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., equipment training: walker, gait training/stair training, transfers training, assist with fall prevention: NA

TEACH PATIENT/CAREGIVER: * 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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car 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, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To be able to walk with a cane

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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 - 06. Independent

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Eating - 06. Independent

Sit to Stand - 06. Independent

Walk 150 Feet - 04. Supervision or touching assistance

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

4 Steps - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/11/2026