Home Health Certification and Plan of Care

Order ID: 1150/21689

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
29292858	08/28/2026	From: 08/28/2026 To: 10/26/2026	5046	217058

6. Patient's Name and Address

Brenda Schoolfield
507 Brightview Dr,
MILLERSVILLE, MD 21108-
540-455-7842

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 03/30/1964 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	08/28/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	08/28/26
M06.4	Inflammatory polyarthropathy	08/28/26
M70.61	Trochanteric bursitis right hip	08/28/26
M72.2	Plantar fascial fibromatosis	08/28/26
H04.123	Dry eye syndrome of bilateral lacrimal glands	08/28/26
Z79.899	Other long term (current) drug therapy	08/28/26
Z87.891	Personal history of nicotine dependence	08/28/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	08/28/26
Z86.0100	Personal history of colonic polyps	08/28/26
Z86.19	Personal history of other infectious and parasitic diseases	08/28/26

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

Lialda - Mesalamine 1.2 gram oral TBEC DR tab , take 4 tablets by mouth once a day
Ecotrin - Aspirin 81 mg oral tbec dr tab by mouth twice a day
Aspirin - Aspirin 81 mg / 1 Tablet by mouth once a day Clotting
Losartan Potassium - Losartan Potassium 25 mg 1 tab by mouth once a day Blood pressure
Milk Of Magnesia - Simethicone 17 gram , Take 17 g by mouth as directed If no BM in 2-3 days take with water for 2 days
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth every 4 hours Pain

14. DME and Supplies:

rolling walker, cane,

15. Safety Measures:

walker precautions, standard precautions, no bending, hip precautions, fall precautions, bathroom safety, ambulates with device, ambulates with assistance

16. Nutrition:

regular,

17. Allergies:

tetracycline

18.A. Functional Limitations

None of the above

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: Yes

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

patient will be responsible for managing treatment

Homebound status: After undergoing Total 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 62-year-old female with a past medical history significant for bilateral hip osteoarthritis who is status post total left hip replacement performed on 8/27/2026. Skilled nursing focus of care is postoperative management requiring continued monitoring, assessment, and education. The patient returned home on the day of surgery with assistance from her son, Leavy, who resides with her. Her daughter-in-law, Jackie, is currently providing additional assistance, and the patient reports that family members are available at all times to provide support. Upon arrival for the skilled nursing visit, the patient was alert and oriented x3 and resting comfortably in a chair with her son present. She denied chest pain or other acute discomfort and reported postoperative pain of 4/10 localized to the left hip surgical site. The patient stated that she is taking her prescribed pain medication as directed and currently reports that her pain is well controlled. An ice pack was in place over the left hip, and the patient reported using ice as instructed. The non-removable postoperative wound dressing was noted to be dry and intact, with instructions for removal in seven days. The patient reported her last bowel movement was yesterday without complications and confirmed that she is following her prescribed bowel regimen. Postoperative discharge instructions were reviewed with the patient. No medication or insurance changes were reported, and no medication refills or missing medications were identified. Admission paperwork was completed and signed, and the patient verbalized agreement with the established plan of care. The patient is scheduled for a surgical follow-up with Dr. Huang on 9/11/2026 and is scheduled to begin outpatient physical therapy on 9/14/2026. The patient demonstrates a significant postoperative decline in endurance, strength, balance, and functional mobility compared with her prior level of function. She currently ambulates with a walker and is required to observe total hip precautions. The patient has 10 steps to enter the rear of the home and remains on the main level at all times. Due to her current functional limitations and postoperative status, she requires assistance from another person and an assistive device to safely leave the home, supporting homebound status. Physical therapy evaluation revealed decreased left hip strength, hip pain, impaired functional mobility, difficulty negotiating steps, unsteady gait, impaired transfers, decreased balance, decreased safety awareness, and increased risk for falls. Skilled home PT is medically necessary to address these impairments and facilitate safe progression toward independent functional mobility and return to prior level of function. Without skilled intervention, the patient remains at increased risk for falls, further functional decline, complications associated with immobility, and loss of independence. The PT plan of care was discussed and developed with the patient and primary caregiver, and both verbalized agreement. Home PT was initiated beginning 8/28/2026 with planned frequency of 1 visit during the first week, 3 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> for one week on Monday/Tuesday/Thursday, and 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> for one week on Tuesday/Thursday, with transition to outpatient PT scheduled for 9/14/2026 following surgical follow-up on 9/11/2026. The patient and caregiver were instructed in total hip precautions, including no hip flexion greater than 90 degrees, no crossing of the midline, and no pivoting or twisting on the operated hip. Education was provided regarding postoperative edema, including positional strategies to reduce swelling such as elevating the lower extremities above heart level during rest periods and using compression garments only if recommended by the physician. The patient verbalized understanding of the education provided. Signs and symptoms of wound or surgical-site infection were reviewed, including fever, chills, redness, swelling, increased or worsening pain, bleeding, drainage, nausea or vomiting that does not improve, and pain that is not adequately controlled with prescribed medication. The patient was instructed to notify her healthcare provider promptly if concerning symptoms occur and to seek emergency medical assistance for chest pain, shortness of breath, or severe/unrelieved symptoms. The patient received instruction in safe transfer techniques using the walker, including appropriate hand and foot placement, forward weight shifting, and reaching back for the chair before sitting. She required standby assistance to complete transfers safely. Bed mobility training was also provided, with instruction regarding proper body mechanics and techniques for safely getting into and out of bed; the patient required minimal assistance to complete bed mobility. Therapeutic exercises were initiated in the supine position, 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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 08/28/2026

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 : 08/20/2026

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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exercise program was left in the home, and the patient was instructed to perform the prescribed exercises twice daily as tolerated. Passive range of motion of the left hip was performed in the supine position within postoperative precautions. Gait training was performed on level surfaces using the walker. The patient required standby assistance for safe ambulation and verbal cues for appropriate positioning within the walker, increased bilateral step height and step length, and overall safety. She was instructed to use the walker at all times during ambulation. The importance and benefits of regular ambulation were reinforced, including promotion of circulation and reduction of complications associated with prolonged inactivity. The patient was instructed to initiate short walks within the home every 1-2 hours, beginning with approximately 1-2 repetitions and gradually progressing longer walking periods from 3-5 minutes as tolerated. Additional education was provided regarding safe use of ice for postoperative pain and edema management. The patient was instructed to apply ice to the left hip for approximately 20 minutes at a time using an appropriate protective barrier and to monitor the skin at frequent intervals. Pain management education was reinforced, including taking prescribed pain medication at the onset of pain as directed, monitoring for potential adverse effects such as dizziness and constipation, and using appropriate precautions during mobility while taking analgesics. The patient was also advised to take prescribed pain medication approximately one hour before PT sessions when appropriate and as directed to facilitate participation in therapy. The patient verbalized understanding through teach-back. Overall, the patient tolerated the initial postoperative skilled nursing and PT interventions without reported acute complications. Continued skilled home health nursing and physical therapy are indicated for postoperative monitoring, reinforcement of hip precautions, pain and edema management, wound surveillance, medication and complication education, therapeutic exercise, gait and transfer training, balance and stair training, fall prevention, and progressive restoration of safe and independent functional mobility until the patient is appropriate for transition to outpatient rehabilitation.
 Date of Order 08/28/2026 Orders Physician Face-to-Face Date: 08/20/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Total 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 (08/28/26-08/29/26) ,WK2: 1 (08/30/26-09/05/26)

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

08/29/2026 Problems : Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
swelling of affected area
limited endurance
limited range of motion
limited strength
B1000 - Vision Deficit
meal preparation

SN Goals

PATIENT-STATED GOAL: To regain my strength and be stable

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

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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* 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	08/28/2026

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D0160 - Depression

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, apply compression bandage, coordinate/arrange preparation of missing meals, 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (08/28/26-08/29/26) ,WK2: 3 (08/30/26-09/05/26) ,WK3: 2 (09/06/26-09/12/26)

08/28/2026 Problems : GG0170P1 - Picking Up Object
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
Pain Interference with ADLs
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 L hip x 20 minutes with necessary barrier and skin assessments q 5 minutes., equipment training: Walker/cane, gait training/stair training, transfers training, assist with fall prevention: Teach falls risk reduction strategies

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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 - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: I would like to feel more stable on my feet

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Shower/Bathe Self - 05. Setup or clean-up assistance

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

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

Walk 150 Feet - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/28/2026