Home Health Certification and Plan of Care

Order ID: 1150/21734

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
999282920	09/02/2026	From: 09/02/2026 To: 10/31/2026	29116	217058

6. Patient's Name and Address

Willette Goudy
6308 Tramore Rd,
Baltimore, MD 21214-
202-271-6235

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 10/11/1961 | **9.Sex** Female

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

NORVASC 5 MG / 1 Tablet by mouth daily
Esidrix - Hydrochlorothiazide 25 MG / 1 Tablet by mouth every morning
Arthritis pain relief 650mg by mouth twice a day Take 1 tablet 2x daily
Oxaydo - Oxycodone Hydrochloride 5mg=1 tablet by mouth every 4 hours Take 1-2 tablets every 4hrs as needed for pain
Aspirin 81Mg - Aspirin 81mg=1tablet by mouth once a day
Colace - Docusate Sodium 100mg=1tablet by mouth twice a day Take 1tablet 2x daily for constipation
Ibuprofen - Ibuprofen 800 mg 800mg=1tablet by mouth every 8 hours Take 1 tablet every 8 hours as needed for pain

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	09/02/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	09/02/26
M16.12	Unilateral primary osteoarthritis left hip	09/02/26
K75.81	Nonalcoholic steatohepatitis (NASH)	09/02/26
I10.	Essential (primary) hypertension	09/02/26
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	09/02/26
E78.5	Hyperlipidemia unspecified	09/02/26
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	09/02/26
E55.9	Vitamin D deficiency unspecified	09/02/26
J30.9	Allergic rhinitis unspecified	09/02/26
D25.9	Leiomyoma of uterus unspecified	09/02/26
Z85.51	Personal history of malignant neoplasm of bladder	09/02/26
Z87.891	Personal history of nicotine dependence	09/02/26

14. DME and Supplies:

walker

15. Safety Measures:

ambulates with device, walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, medication safety, standard precautions, fall precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Transfer bed/Chair, Walker, Exercises Prescribed, 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

patient will be responsible for managing treatment
family/caregiver 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:

Home health skilled nursing admission and physical therapy assessment were completed for a 64-year-old female status post right total hip replacement. The patient's past medical history is significant for osteoarthritis, hypertension, hyperlipidemia, vitamin D deficiency, and bladder cancer with a history of surgical resection. The patient is alert and oriented 4 and resides with her daughter, who provides assistance with care as needed. Following the recent surgery, the patient demonstrates decreased mobility and requires a rolling walker for safe ambulation, resulting in an increased risk for falls. Vital signs were within normal limits, and the patient was in stable condition at the time of the visit. The right hip surgical dressing was assessed and noted to be clean, dry, and intact, with no visible signs of infection or other postoperative complications. Medication reconciliation was completed, and the patient's current medications were reviewed. Skilled nursing provided education regarding medication management, pain management, postoperative swelling reduction strategies, fall prevention, proper use of the assistive device, and surgical-site monitoring. The patient was instructed to observe the surgical site for signs and symptoms of infection or other postoperative complications, including increased redness, swelling, drainage, worsening pain, fever, or other changes in condition, and to promptly notify the healthcare provider if such symptoms occur. The patient verbalized understanding of the education provided. Continued skilled nursing is indicated for postoperative assessment, medication and pain-management education, surgical-site monitoring, and prevention or early identification of complications. During the physical therapy evaluation, the patient ambulated approximately 40 feet 2 on indoor level surfaces using a rolling walker with supervision and verbal cues for appropriate gait pattern and safety. She performed transfers to the bed, toilet, and chair with supervision. Bed mobility was completed with supervision and verbal cues to decrease hip flexion and maintain appropriate postoperative positioning. Stair negotiation, outdoor mobility, and car-transfer skills were not assessed during the evaluation. The patient tolerated 10 repetitions of quadriceps sets, gluteal sets, hip flexion, bridging, seated knee extension, and ankle pumps. The patient was educated regarding postoperative hip precautions, specifically instructed not to cross her legs and to avoid hip flexion greater than 90 degrees to promote safe healing and reduce the risk of postoperative complications. Reinforcement of hip precautions, safe transfer techniques, appropriate walker use, and fall-prevention strategies is indicated throughout the episode of care. The patient is considered homebound due to the significant effort required to leave the home following surgery, impaired functional mobility, need for an assistive device, and increased fall risk, as supported by a Tinetti score of 14/28. Continued skilled home health physical therapy is medically necessary to improve lower-extremity strength, balance, gait mechanics, transfers, functional mobility, and safety awareness and to facilitate progression toward the patient's prior level of independence. Skilled nursing will continue to monitor postoperative recovery, medication and pain-management needs, surgical-site condition, and potential complications. The overall plan of care is directed toward promoting safe recovery following right total hip replacement, reducing fall and postoperative complication risks, and restoring the patient's functional independence within the home.
 Date of Order 09/02/2026 Orders Physician Face-to-Face Date: 08/26/2026 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:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 09/02/2026

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 : 08/26/2026

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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eval
 Physician Huang, James

SN Careplans

SN frequency WK1: 1 (09/02/26-09/05/26) ,WK2: 1 (09/06/26-09/12/26)

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: 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

09/03/2026 Problems : #1 - Non-Observable Surgical Wound - Other - Right hip -
A1250 - Lack of Necessary Transportation
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
balance deficit
limited endurance
limited range of motion
limited strength
B1000 - Vision Deficit
meal preparation
M2102c - Med Admin
M2102f - Patient Supervision
M2102d - Caregiver Performs Treatment

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Right hip -, cough/deep breathing exercises, incentive spirometer, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

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

SN Goals

PATIENT-STATED GOAL: Patient stated she would like to heal properly from surgery without difficulty

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's transportation needs are met

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	09/02/2026

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self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT frequency WK1: 1 (09/02/26-09/05/26) ,WK2: 3 (09/06/26-09/12/26) ,WK3: 2 (09/13/26-09/19/26)

09/02/2026 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
GG0170G1 - Car Transfer
Pain Interference with ADLs
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
GG0170F1 - Toilet Transfer
GG0170D1 - Sit to Stand

PROCEDURES: Hip precautions training : Avoid flexion greater than 90 degrees., home exercise program: Quad sets, glut sets, hip flexion, bridging, hip abduction. Standing knee flexion, hip abduction, plantarflexion, squats. Sitting knee extension, ankle pumps, equipment training, gait training on uneven surfaces, gait training/stair training, transfers training

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 - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 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, Car Transfer - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 02. Substantial/maximal 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 walk with my cane without pain and be able to move my leg

GOALS
Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 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 - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

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

Car Transfer - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	09/02/2026