HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022020

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
74271816	09/10/2026	09/10/2026 - 11/08/2026	29384	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Cynthia Dickerson 23 Dublin Dr Lutherville, MD 21093	Female	08/30/1973	410-512-7946
	Email		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI: 1487113239		Fax Number: 410-559-3002

Clinical Condition Requiring Homecare:

Skilled nursing admission was completed for a 52-year-old female status post left total hip replacement performed on 09/09/2026, with same-day discharge from surgery. Past medical history includes left hip osteoarthritis, hypothyroidism, prior cesarean section, and hysterectomy. The patient is alert and oriented x4 and resides with her sister, who provides 24-hour caregiver support and assistance with daily needs. The patient denies chest pain, fever, nausea, or vomiting. Lungs are clear to auscultation. Abdomen is flat with normoactive bowel sounds, and last bowel movement was reported as yesterday. Vital signs were within acceptable parameters. The patient is wearing compression stockings for circulation and edema management. No signs or symptoms of infection or acute postoperative complications were observed. The patient is tolerating movement and maintaining a toileting schedule. Skilled nursing completed medication reconciliation and provided education regarding medication effects, potential adverse reactions, and safety precautions. The patient was specifically educated regarding the potential constipating effects of postoperative/pain medications and the importance of maintaining regular bowel function, with instructions to notify the healthcare provider if she does not have a bowel movement within three days. Infection-prevention education was provided to the patient and caregiver, including proper hand hygiene and monitoring the surgical site for signs and symptoms of infection such as fever, chills, increased redness, swelling, worsening pain, bleeding, or drainage. The patient and caregiver were instructed to notify the healthcare provider promptly if concerning symptoms develop and verbalized understanding of all teaching provided. The patient was informed that skilled nursing will remove the postoperative dressing seven days after the procedure according to the postoperative plan of care. Skilled home health physical therapy evaluation was also completed for the patient following left total hip replacement on 09/09/2026. The patient presents with expected postoperative left lower-extremity weakness, pain and stiffness.

Physician Statement on Homebound Status:

After undergoing Left 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.

decreased balance, impaired gait mechanics, and reduced functional endurance, resulting in limitations with bed mobility, transfers, and household ambulation. Bed mobility requires increased time and use of upper-extremity support. Transfers require contact guard assistance (CGA), with instruction provided regarding safe transfer techniques and adherence to prescribed joint-protection/postoperative precautions. The patient is able to ambulate short household distances with an assistive device and CGA due to impaired strength, balance, and endurance. The surgical incision is covered with an Aquacel dressing, which is intact with no acute concerns noted at the time of evaluation. The patient received education regarding postoperative precautions, medication management, pain and edema control, incision monitoring, recognition of signs and symptoms of infection, fall prevention, and compliance with the prescribed home exercise program (HEP). Skilled home health PT is medically necessary to address postoperative deficits through therapeutic exercise, left lower-extremity range-of-motion and strengthening activities, gait and transfer training, balance and functional mobility interventions, safety education, and progressive training with the appropriate assistive device. Continued skilled PT will focus on improving strength, mobility, balance, endurance, transfer safety, gait mechanics, and adherence to postoperative precautions to facilitate safe and progressive independence with functional mobility in the home. The patient and caregiver are in agreement with the plan of care and demonstrated understanding of the education provided.

Date of Order
09/10/2026
Orders
Physician Face-to-Face Date: 08/19/2026
Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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
Huang, James

ICD-10 CM Principal Diagnosis: Z47.1. Aftercare following joint replacement surgery

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
Z96.642	Presence of left artificial hip joint	ECOTRIN LOW STRENGTH DR 81 MG / 1 Tablet by mouth 2 times a day COLACE 100 MG / 1 Capsule by mouth 2 times a day LIPITOR 40 MG / 1 Tablet by mouth daily for cholesterol and heart protection Synthroid - Levothyroxine Sodium 50 MCG / 1 Tablet by mouth every morning 30 minutes before a meal Lotrimin Af - Clotrimazole 1 % Top Cream / Apply to affected area(s) topical twice a day
M47.22	Other spondylosis with radiculopathy cervical region	
D22.9	Melanocytic nevi unspecified	
J45.909	Unspecified asthma uncomplicated	
G47.33	Obstructive sleep apnea (adult) (pediatric)	

I70.0	Atherosclerosis of aorta	area(s) topical twice a day SINGULAIR 10 MG / 1 Tablet by mouth every evening Zinc Oxide - Zinc Oxide 20 % Top Ointment / Apply to affected area(s) topical as necessary in the buttock area. Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50 mcg (2,000 unit) Tablet / Take 2.5 tablets by mouth once a day Aspirin 81Mg - Aspirin 81 by mouth twice a day Oxycodone 5/Apap 500 - Acetaminophen: Oxycodone Hydrochloride 5mg by mouth every 4 hours Pain over 5
E03.9	Hypothyroidism unspecified	
F43.23	Adjustment disorder with mixed anxiety and depressed mood	
G47.00	Insomnia unspecified	
L29.0	Pruritus ani	
E78.5	Hyperlipidemia unspecified	
E55.9	Vitamin D deficiency unspecified	
K64.9	Unspecified hemorrhoids	
E66.9	Obesity unspecified	
Z68.38	Body mass index [BMI] 38.0-38.9 adult	
Z79.82	Long term (current) use of aspirin	
Z90.710	Acquired absence of both cervix and uterus	

Prognosis fair	**Mental and Psychosocial 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
Functional Limitations Endurance, , Dyspnea With Minimal Exertion	**Activities Permitted** Up As Tolerated, Wheelchair, Walker
DME & Supplies rolling walker, bath bench, wheelchair, , , 4 wheeled walker	**Safety Measures** infectious material management, standard precautions, fall precautions, wheelchair precautions, , walker precautions, hip precautions, , bathroom safety, ambulates with device
Nutrition Z. NO PHYSICIAN-ORDERED DIET	**Allergies** no known allergies

Advance Directives
POLST (s for Life-Sustaining Treatment)

Caregiver Status
2. Non-agency caregiver(s) need training/supportive services to provide assistance; 1. Non-agency caregiver(s) currently provide assistance

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.

DISCHARGE PLAN:
SN: patient will be responsible for managing treatment
PT: family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

PT Eval: eval

SN CAREPLAN

SN frequency WK1: 1 (09/10/26-09/12/26),WK2: 1 (09/13/26-09/19/26)

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:POLST (Physician Orders for Life-Sustaining Treatment)

09/16/2026 Problems : #1 - Non-Observable Surgical Wound - Anterior Left Hip -
M1400 - Dyspnea
M2020 - Oral Med Management
weight gain > 2lb/24 h OR 5lb/1 wk
daytime fatigue
difficulty sleeping
balance deficit
swelling of affected area
limited endurance
limited strength

SN NARRATIVE

Skilled nursing admission completed for a Patient completed left hip replacement. PMH c-SECTION, hysterectomy, hypothyroidism. The patient was released from same day surgery after a left hip replacement. Patient is alert and oriented 4. Patient lives with sister as primary caregiver 24 hpur care. Patient denies chest pain, fever, nausea and vomitting. Lungs clear on auscultation. Abdomen flat with normoactive bowel sounds LBM yesterday. Assessment completed with vital signs within acceptable parameters. Patient has on compression stockings for circulation. no signs or symptoms of infection or complications. Patient is able to tolerate movement and toilet schedule. Skilled nursing provided education to the patient and caregiver on infection precautions, including recognizing signs and symptoms of infection, and when to notify the provider. Instruction was also provided on proper hand hygiene. Patient and caregiver verbalized understanding of all teaching. Skilled nursing reconciled medical, education on effects and adverse reaction. Patient was educated on medication effects of constipation and the importance to move bowels within 3 day. Patient instructed sn will remove dressing seven day post procedure.

Skilled nursing admission completed for a Patient completed left hip replacement. Patient is a 52 year old female with PMH c-SECTION, hysterectomy, hypothyroidism. The patient was released from same day surgery after a left hip replacement. Patient is alert and oriented 4. Patient lives with sister as primary caregiver 24 hpur care. Patient denies chest pain, fever, nausea and vomitting. Lungs clear on auscultation. Abdomen flat with normoactive bowel sounds LBM yesterday. Assessment completed with vital signs within acceptable parameters. Patient has on compression stockings for circulation. no signs or symptoms of infection or complications. Patient is able to tolerate movement and toilet schedule. Skilled nursing provided education to the patient and caregiver on infection precautions, including recognizing signs and symptoms of infection, and when to notify the provider. Instruction was also provided on proper hand hygiene. Patient and caregiver verbalized understanding of all teaching. Skilled nursing reconciled medical, education on effects and adverse reaction. Patient was educated on medication effects of constipation and the importance to move bowels within 3 day. Patient instructed sn will remove dressing seven day post procedure.

SN GOALS

PATIENT-STATED GOAL: 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

constipation obesity discolored patches of skin swell/redness surround. skin abnormal thyroid <> 0.40 - 4.50 mIU/mL B1000 - Vision Deficit M2102c - Med Admin M2102d - Caregiver Performs Treatment PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left 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, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration 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 achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence	

PT CAREPLAN
PT frequency WK1: 1 (09/10/26-09/12/26),WK2: 3 (09/13/26-09/19/26),WK3: 2 (09/20/26-09/26/26)

09/11/2026 Problems : GG0170O1 - 12 Steps
GG0130F1 - Upper Body Dressing
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene
GG0170E1 - Chair to Bed to Chair
GG0170P1 - Picking Up Object
GG0170D1 - Sit to Stand
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

PROCEDURES: B LE mm strengthening: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PT NARRATIVE
Pt is a 53-year-old female with PMH of left hip OA, referred for skilled home health PT evaluation s/p left total hip replacement on 9/9/26. Pt presents with expected post-operative LLE weakness, pain/stiffness, decreased balance, and impaired gait mechanics, limiting bed mobility, transfers, and household ambulation. Bed mobility requires increased time and use of UE support; transfers require CGA with instruction in safe technique and joint-protection precautions. Pt ambulates short household distances with AD and CGA due to impaired strength, balance, and endurance. Surgical incision is covered with Aquacel dressing; dressing intact with no noted acute concerns. Pt educated regarding post-operative precautions, medication management, pain/edema control, incision monitoring, signs/symptoms of infection, fall prevention, and HEP. Skilled HHPT is medically necessary for therapeutic exercise, ROM/strengthening, gait and transfer training, balance, safety education, and progression toward safe independent household mobility.

PT GOALS
PATIENT-STATED GOAL: To have a successful post surgical outcome

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Upper Body Dressing - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/10/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.
F2F date: 08/19/2026

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.

Certifying Physician or Allowed Practitioner Name and Address **James Huang**
8028 Ritchie Hwy
Pasadena, MD 21122
NPI 1154567709

Phone Number 410-737-5600

Fax Number 14107375391

Physician's Signature and Date Signed

X

James Huang
08/19/2026: Date of physician last face-to-face

Dickerson, Cynthia | Cert Period 09/10/26 - 11/08/26