HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022136

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
931038300	09/16/2026	09/16/2026 - 11/14/2026	29664	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Nakia Savoy 2611 Park Heights Ter BALTIMORE, MD 21215	Female	05/22/1975	202-718-7333
	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 SOC was completed, and consents were signed by the patient. The patient is a 51-year-old female status post left hip joint replacement surgery performed by Dr. Huang. Following surgery, the patient requires a walker and one-person assistance for safe mobility and fall prevention. The patient is alert and oriented x4 and reports postoperative pain rated 2/10. She ambulates with a walker and denies any falls. Her last bowel movement was yesterday. The patient was educated regarding the use of stool softeners as part of a bowel regimen to prevent constipation associated with oxycodone use. She reports a good appetite, and postoperative nausea has subsided. The patient has partial upper dentures and denies any difficulty eating, stating that she is currently hungry. Her sister, Tanya, is present in the home and assists with caregiving. The patient denies urinary discomfort, dizziness, or lightheadedness and reports sleeping well. Hydration was encouraged to help prevent dehydration. All medications were reviewed, and education was provided regarding pain management, including prescribed anti-inflammatory medications and ice therapy as directed. The patient was instructed on postoperative dressing care, including keeping the dressing dry and avoiding soaking the surgical site. No other wounds were noted on assessment. The patient demonstrates correct operation of the incentive spirometer. No abnormal bleeding or abnormal lung sounds were noted. The patient was instructed to contact the surgeon immediately for any increase in bruising, pain, or swelling. The patient was also informed of the planned nursing return visit, during which the dressing will be removed and the incision site assessed, measured, and photographed. Follow-up with Dr. Huang is scheduled for 9/30/26 at 11:10 AM. PT evaluation was completed following the patient's left total hip arthroplasty. Prior to surgery, the patient was independently ambulatory without an assistive device but occasionally used a single-point cane. Currently, the patient demonstrates significant left lower-extremity weakness, with strength measured at 2-/5 on manual muscle testing, resulting in impaired

Physician Statement on Homebound Status:

After undergoing Left hip joint 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.

functional mobility. The patient was instructed in an initial home exercise program consisting of seated therapeutic exercises with emphasis on stretching and maintaining prescribed hip precautions. She requires contact guard assistance (CGA) for transfers and short-distance ambulation using a rolling walker, with verbal cues provided to improve trunk extension and step length. Skilled PT services are medically necessary to address decreased strength and ROM, impaired mobility, and safety deficits, with the goals of improving functional strength and ROM, promoting safe transfers and ambulation, reinforcing hip precautions and fall prevention, and facilitating return to the patient's prior level of function.

Date of Order
09/16/2026
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 Left hip joint replacement surgery
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	CLIMARA 0.025 mg/24 hr TD Weekly Patch transdermal as directed Apply 1 Patch to skin every 7 days Ventolin - Albuterol 90 mcg/actuation Inhl HFAA / Inhale 1 Puff by mouth as necessary every 4 hours (rescue inhaler) TEMOVATE 0.05 % Top Ointment / Apply to affected area(s) topical twice a day Do not apply to the face, groin, genitals or buttocks Zyzol tablet by mouth as necessary Allergies Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg (1-2 tablets) by mouth every 4 hours As needed for post surgical pain Colace - Docusate Sodium 100mg by mouth twice a day 1-2 tablets for stool softener Extra Strength Tylenol - Acetaminophen 500mg by mouth every 6 hours 1-2 tablet for inflammation Aspirin 81Mg - Aspirin 81mg by mouth once a day Black Girl Vitamins B12 Tab by mouth once a day Supplements Black Girl Vitamins Minna Chill Tab by mouth once a day Supplements for menopause Black Girl Vitamins D3 K2 Tablet by mouth once a day Supplements
I10.	Essential (primary) hypertension	
J45.909	Unspecified asthma uncomplicated	
M54.32	Sciatica left side	
J30.2	Other seasonal allergic rhinitis	
L30.9	Dermatitis unspecified	
M77.32	Calcaneal spur left foot	
Z87.891	Personal history of nicotine dependence	

Prognosis
good

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
Ambulation, Endurance

Activities Permitted
Up As Tolerated, Exercises Prescribed, Walker, Cane

DME & Supplies	Safety Measures
hand held shower, bath bench, cane, walker	no bending, smoke detectors , emergency phone # clearly displayed, hand rails, restricted ROM, transfer with assist, bleeding precautions, walker precautions, supervision at all times, standard precautions, medication safety, hip precautions, fall precautions, bathroom safety, ambulates with device, ambulates with assistance, activity supervision
Nutrition	**Allergies**
Z. NO PHYSICIAN-ORDERED DIET	no known allergies

Advance Directives
Na

Caregiver Status
2. Non-agency caregiver(s) need training/supportive services to provide assistance; 2. Non-agency caregiver(s) need training/supportive services to 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: patient will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

PT Eval: eval

SN CAREPLAN

SN frequency WK1: 1 (09/16/26-09/19/26),WK2: 1 (09/20/26-09/26/26)

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; 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 ; 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.

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Advance Directive:Na

09/22/2026 Problems : #1 - Non-Observable Surgical Wound - Anterior Left Hip -
muscle weakness (MS)
limited strength (MS)
itchy/runny nose (CR)

SN NARRATIVE

SOC

Consents signed by patient.

S/p left knee joint replacement surgery requires walker and one person assist for safety and prevent accidental falls.

Surgeon Dr . Huang

Patient is alert and oriented x4. Patent reports pain 2. Patient ambulates with walker for safety and fall prevention. Patient denies falls. Patient reports last bowel movement was yesterday. Patient instructed on stool softeners for bowel regimen to prevent constipation on oxycodone. Patient reports appetite okay. No nausea post surgery has subsided. Patient has partial upper dentures. No issues with eating per patient's report, states she is hungry now. Patient's sister Tanya is in home caregivers. Patient denies discomfort with urination. Patient instructed on hydration to prevent dehydration. Patient reports sleeping well. Good appetite. Patient instructed on dressing care, not to get wlet or soak. No other wounds noted on assessment. Patient denies dizziness or light headedness. All medications reviewed. Patient instructed on pain management with anti-inflammatory medications administered. Patient instructed on ice therapy as directed. Patient demonstrates correct operation of Incentive spirometer. Patient instructed on nurse return visit. Dressing will be removed, incision site to assessed, and measured and photo will be obtained. Patient instructed to contact surgeon immediately if there is an increase in bruising, pain or swelling. No abnormal bleeding reported. No abnormal bleeding reported. No abnormal lung sounds noted. Dr Huang 9/30/26 11 10am.

SOC

Consents signed by patient.

S/p left hip joint replacement surgery requires walker and one person assist for safety and prevent accidental falls.

Surgeon Dr . Huang

Patient is alert and oriented x4. Patent reports pain 2. Patient ambulates with walker for safety and fall prevention. Patient denies falls. Patient reports last bowel movement was yesterday. Patient instructed on stool softeners for bowel regimen to prevent constipation on oxycodone. Patient reports appetite okay. No nausea post surgery has subsided. Patient has partial upper dentures. No issues with eating per patient's report, states she is hungry now. Patient's sister Tanya is in home caregivers. Patient denies discomfort with urination. Patient instructed on hydration to prevent dehydration. Patient reports sleeping well. Good appetite. Patient instructed on dressing care, not to get wet or soak. No other wounds noted on assessment. Patient denies dizziness or light headedness. All medications reviewed. Patient instructed on pain management with anti-inflammatory medications administered. Patient instructed on ice therapy as directed. Patient demonstrates correct operation of Incentive spirometer. Patient instructed on nurse return visit. Dressing will be removed, incision site to assessed, and measured and photo will be obtained. Patient instructed to contact surgeon immediately if there is an increase in bruising, pain or swelling. No abnormal bleeding reported. No abnormal bleeding reported. No abnormal lung sounds noted. Dr Huang 9/30/26 11 10am.

SN GOALS

PATIENT-STATED GOAL: Reduce hip 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

Pain Effect on Sleep Pain Interference with Therapy activities Pain Interference with ADLs M1400 - Dyspnea M2020 - Oral Med Management abnormal blood pressure pain radiating to arms/legs balance deficit swelling of affected area limited endurance limited range of motion swell/redness surround. skin meal preparation M2102f - Patient Supervision M2102d - Caregiver Performs Treatment M2102c - Med Admin PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Hip -: Keep dry and intact, cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence	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 * 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 patient is adequately supervised meal preparation is available to patient for all meals caregiver performs medical/rehabilitation treatments with adequate competence

PT CAREPLAN
PT frequency WK1: 2 (09/16/26-09/19/26),WK2: 2 (09/20/26-09/26/26),WK3: 2 (09/27/26-10/03/26)

09/16/2026 Problems : GG0170P1 - Picking Up Object
GG0130A1 - Eating
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130F1 - Upper Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170E1 - Chair to Bed to Chair
GG0170G1 - Car Transfer
Pain Effect on Sleep
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
GG0170F1 - Toilet Transfer
GG0170D1 - Sit to Stand
Pain Interference with ADLs
Pain Interference with Therapy activities

PROCEDURES: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Review HEP: Standing heel/toe raises, knee flex, hip flex, hip abd, hip add at least 1x10 with UE support as needed. Upgrade as tolerated, maintaining hip precautions, equipment training, work simplification/energy conservation, 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 - 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent

PT NARRATIVE
PT eval completed. Pt is a 51 y.o. female who underwent L THA yesterday. Prior to surgery, pt had been ambulating with no AD independently but did use SPC occasionally. At this time, pt presents with decreased strength with 2-/5 MMT in LLE. PT instructed pt in initial HEP for seated therex, focusing of stretching asks maintaining hip precautions. Pt requires CGA for transfers and short distance ambulation with RW and focus on increasing trunk ext and step length. Pt would benefit from skilled PT services to increase strength and ROM and increase safety in mobility in order to return to PLOF.

PT GOALS
PATIENT-STATED GOAL: To be able to walk without pain

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

Walk 150 Feet - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

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

Don/Doff Footwear - 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

Walk 10 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 - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

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

Eating - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/16/2026

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: 08/26/2026

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
08/26/2026: Date of physician last face-to-face

Savoy, Nakia | Cert Period 09/16/26 - 11/14/26