HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022153

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
56195033	09/17/2026	09/17/2026 - 11/15/2026	29562	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Lillie Jacobs 523 Allendale St Baltimore, MD 21229	Female	11/06/1947	410-945-0333
	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:

The patient is a 78-year-old male status post right total hip replacement due to right hip osteoarthritis, with a medical history significant for left knee osteoarthritis, hypertension, chronic kidney disease, and diabetes mellitus. He lives with his son and daughter in a townhouse with three curb steps to enter and bedrooms and bathroom located on the second floor with bilateral handrails. The patient is alert and oriented 3 and reports right hip pain rated 8/10. He denies shortness of breath; lung sounds are clear throughout. He reports a fair appetite, and his last bowel movement was prior to surgery. The right hip surgical dressing is intact, and the patient is wearing compression stockings and using a walker for safe ambulation. He requires family assistance with ADLs and IADLs. He ambulates approximately 25 feet 2 indoors with a rolling walker and contact-guard assistance, requires moderate assistance for bed mobility, particularly with lower-extremity management, and performs sit-to-stand transfers to the bed, chair, or bedside commode with supervision. He tolerated prescribed therapeutic exercises, including sitting knee extensions, ankle pumps, supine hip flexion, quadriceps sets, gluteal sets, and bridging. Skilled nursing provided medication education, including medication names, doses, frequencies, and pertinent side effects, as well as instruction on effective pain management and proper use of compression stockings; the patient/caregiver verbalized understanding. The patient is homebound due to the significant effort required to leave the home and impaired mobility, as evidenced by a Tinetti score of 12/28, and would benefit from continued skilled home health PT to improve strength, balance, functional mobility, safety, and independence.<o:p></o:p>

Date of Order<o:p></o:p>
09/17/2026
Physician Face-to-Face Date:
09/03/2026<o:p></o:p>
Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Hip Replacement

Physician Statement on Homebound Status:

After undergoing Right Total Hip 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.

surgery<o:p></o:p>
Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>

1 - SOC - SN Notes:<o:p></o:p>
PT Eval Notes:<o:p></o:p>
Physician: Huang, James

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

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
I10.	Essential (primary) hypertension	NORVASC eq 10 mg base 10 MG / 1 Tablet by mouth daily for blood pressure Asa 81 Mg - Aspirin 81MG; 1 TAB by mouth twice a day POST RIGHT THR LIPITOR eq 40 mg base 40 MG / 1 Tablet by mouth every evening CHOLESTEROL COREG 25 mg 25 MG / 1 Tablet by mouth 2 times a day with meals BLOOD PRESSURE COLACE 100 MG Capsule by mouth once a day BOWEL REGIMEN Glipizide - Glipizide 10 mg 10MG; 1 1/2 TAB by mouth twice a day DM APRESOLINE 100 mg 100 MG / 1 Tablet by mouth 3 times a day BLOOD PRESSURE COZAAR 100 mg 100 MG / 1 Tablet by mouth daily BLOOD PRESSURE TYLENOL 500 MG / 1 Tablet by mouth every 6 hours as needed for fever Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50 mcg (2000 unit) / 1 Capsule by mouth daily SUPPLEMENT Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5MG; 1 TAB by mouth every 4 hours AS NEEDED FOR PAIN
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	
N18.32	Chronic kidney disease stage 3b	
M17.0	Bilateral primary osteoarthritis of knee	
H90.3	Sensorineural hearing loss bilateral	
I70.0	Atherosclerosis of aorta	
M10.9	Gout unspecified	
E78.5	Hyperlipidemia unspecified	
K80.20	Calculus of gallbladder w/o cholecystitis w/o obstruction	
E55.9	Vitamin D deficiency unspecified	
H04.123	Dry eye syndrome of bilateral lacrimal glands	
Z79.84	Long term (current) use of oral hypoglycemic drugs	
Z97.4	Presence of external hearing-aid	
Z86.0100	Personal history of colonic polyps	
Z96.643	Presence of artificial hip joint bilateral	

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, Cane, Walker, Exercises Prescribed

DME & Supplies
walker, cane

Safety Measures
restricted ROM, no bending, hand rails, emergency phone # clearly displayed, smoke detectors , cardiac precautions, bathroom safety, standard precautions, fall precautions, diabetic precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, ambulates with assistance, transfer with assist, supervision at all times, hip precautions, anticoagulant precautions, activity supervision

Nutrition
cardiac diet, diabetic

Allergies
doxazosin mesylate

hctz

Advance Directives
No Advance Directive

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: 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.

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 (09/17/26-09/19/26),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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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.

RIGHT HIP
Advance Directive:No Advance Directive

09/21/2026 Problems : #1 - Non-Observable Surgical Wound - Other - RIGHT HIP - DRESSING INTACT
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
abnormal blood pressure

SN NARRATIVE

PATIENT S/P RIGHT THR. DX WITH ARTHRITIS OF RIGHT HIP. SN FREQ 1W2; PT EVAL COMPLETED TODAY. FAMILY ASSIST WITH ALL ADL'S AND IADL'S.

PATIENT ALERT AND ORIENTED X3; REPORTS PAIN AS 8/10; DENIES SOB, LUNGS CLEAR THROUGHOUT, REPORTS FAIR APPETITE, LBM PRIOR TO SURGERY, RIGHT HIP DRESSING INTACT, PT WEARING COMPRESSION STOCKINGS; USING A WALKER FOR SAFE AMBULATION.

SN REVIEWED ALL MEDICATIONS, DOSE, FREQUENCY AND PERTINENT SIDE EFFECTS; INSTRUCTED ON EFFECTIVE PAIN MANAGEMENT; PROPER USE OF WEARING COMPRESSION STOCKINGS; PT.CG VERBALIZED UNDERSTANDING.

SN GOALS

PATIENT-STATED GOAL: I WANT PAIN TO IMPROVE

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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* 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

balance deficit limited range of motion limited strength limited endurance meal preparation swelling of affected area muscle weakness M2102f - Patient Supervision M2102d - Caregiver Performs Treatment PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - RIGHT HIP - DRESSING INTACT: SN TO REMOVE RIGHT HIP DRESSING POST OP DAY 7, cough/deep breathing exercises, incentive spirometer 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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals	

PT CAREPLAN
PT frequency WK1: 2 (09/17/26-09/19/26),WK2: 3 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26)

09/17/2026 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
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

PROCEDURES: Bed mobility training : Sit to supine and supine to sit, Family training: Bed mobility, hip precautions, steps, home exercise program: Quad sets, glut sets, hip flexion, bridging. Standing knee flexion, hip abduction, plantarflexion, squats, knee extension, ankle pumps, equipment training, 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, 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 - 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 - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT NARRATIVE
Client is a 78 year old with right hip replacement. History includes OA right hip and left knee, HTN, CKD, DM. Lives with son and daughter in townhouse with 3 curb steps to enter. Bed and bath on 2nd floor with bilateral rails. Ambulates on indoor surface 25 feet x 2 with contact guard. Bed mobility is with moderate assistance at legs. Transfers sit to stand to bed, chair or bedside commode with supervision. Tolerates 10 reps of sitting knee extension, ankle pumps. Supine hip flexion, quad sets, glut sets, bridging. Client is homebound due to significant effort to leave home with rolling walker and as evidenced by tinetti score of 12/28. Client would benefit from home therapy to increase strength and return to independence.

PT GOALS
PATIENT-STATED GOAL: To be able to get around by myself

GOALS
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

Toilet Transfer - 05. Setup or clean-up 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

Don/Doff Footwear - 03. Partial/moderate assistance

Upper Body Dressing - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

Lower Body Dressing - 03. Partial/moderate assistance

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/17/2026

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: 09/03/2026

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
09/03/2026: Date of physician last face-to-face

Jacobs, Lillie | Cert Period 09/17/26 - 11/15/26