Order Number:
12212228

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
100201839287	5/17/2025	5/17/2025 to 7/15/2025	C0200241665301	227203

Patient's Name and Address:
RUSSELL A BOLTON (508) 996-5517
45 SABLE AVE
N DARTMOUTH, MA 02747-

Provider's Name, Address and Telephone Number:
ACCENTCARE OF MASS, INC. DBA AC HH OF MASS F: (508) 730-3436
21 FATHER DEVALLES BLVD STE 104
FALL RIVER, MA 02723- P: (508) 235-5312

Physician's Name & Address: P: (508)996-3991 F: (508)990-3218

COLM MCCARTHY, MD
531 FAUNCE CORNER RD
NORTH DARTMOUTH, MA 02747-

Patient's Date of Birth: 6/16/1960
Patient's Gender: MALE
Order Date: 5/17/2025 1:59 PM
Verbal Order: Y
Verbal Date: 5/17/2025
Verbal Time: 2:53 PM

Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature)
JENNA-MAE ARRUDA, RN / LISA COUGHLIN RN 5/17/2025

Date HHA Received Signed POC

Patient's Expressed Goals:
TO GET BACK TO WORK

ICD-10 Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	Z47.1	AFTERCARE FOLLOWING JOINT REPLACEMENT SURGERY	EXACERBATION	05/17/2025
2	I10	ESSENTIAL (PRIMARY) HYPERTENSION	EXACERBATION	05/17/2025
3	E11.9	TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS	EXACERBATION	05/17/2025
4	E78.5	HYPERLIPIDEMIA, UNSPECIFIED	EXACERBATION	05/17/2025
5	Z96.642	PRESENCE OF LEFT ARTIFICIAL HIP JOINT	EXACERBATION	05/15/2025
6	Z79.82	LONG TERM (CURRENT) USE OF ASPIRIN	EXACERBATION	05/17/2025
7	Z79.84	LONG TERM (CURRENT) USE OF ORAL HYPOGLYCEMIC DRUGS	EXACERBATION	05/17/2025

Frequency/Duration of Visits:
SN 1WK1,1EVERY2WK2
PT 1WK1,2WK2,1WK2

Orders of Discipline and Treatments:
---------- INITIAL COMPREHENSIVE OASIS ASSESSMENT COMPLETED ON (64YO M) REFERRED BY DR MCCARTHY) FOR HOME HEALTH SKILLED SERVICES TO BE FOLLOWED BY PCP/SPECIALIST, DR MCCARTHY FOLLOWING DC FROM HOSPITAL. THE PATIENT'S MEDICAL HISTORY INCLUDES OSTEOARTHRITIS, HIGH CHOLESTEROL, TYPE2DM. THERE IS NOT A PAID CAREGIVER TO PROVIDE ASSISTANCE IN THE HOME. THE PATIENT IS TEACHABLE AND IS ABLE TO PARTICIPATE IN SELF-CARE. FAMILY OR CAREGIVER IS NOT WILLING, ABLE, AND AVAILABLE TO ASSIST/INSTRUCT/INTERVENE ON BEHALF OF PATIENT.

SKILLED NURSE TO EVALUATE AND DEVELOP PLAN OF CARE TO BE COUNTERSIGNED BY PHYSICIAN. SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING OSTEOARTHRITIS, HIGH CHOLESTEROL, TYPE 2 DIABETES AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. MAY COMPLETE A ROC ASSESSMENT UPON HOSPITAL DISCHARGE DURING THIS EPISODE IF NEEDED. MAY SCHEDULE A BH RN EVALUATION AS NEEDED DURING THE EPISODE TO ASSESS FOR IMPACT OF BEHAVIOR, MEDICATIONS AND/OR NEED FOR FOLLOW-UP.MAY CONSULT SOCIAL WORKER FOR ADVANCED CARE PLANNING, GOALS OF CARE, AND PATIENT ADVOCACY. MAY PERFORM O2 SATURATION LEVEL AT EVALUATION VISIT AND PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS AND NOTIFY MD OF O2 LEVELS BELOW 92.

SKILLED NURSING IS MEDICALLY NECESSARY FOR SKILLED OBSERVATION AND ASSESSMENT OF (OSTEOARTHRITIS LEFT HIP ARTHOPLASTY) DUE TO THE REASONABLE POTENTIAL FOR HOSPITALIZATION, COMPLICATION, EXACERBATION, AND/OR CHANGE IN TREATMENT WITHIN THE NEXT THREE WEEKS. THE SKILLS OF THE NURSE ARE NECESSARY TO OBSERVE CHANGES IN THE PATIENT'S CONDITION AND REPORT CHANGES TO THE PHYSICIAN FOR POSSIBLE ALTERATION IN THE TREATMENT PLAN OR ADDITIONAL PROCEDURES UNTIL THE PATIENT'S CONDITION HAS STABILIZED.

RECENT EXACERBATION, NEW OR CHANGED DIAGNOSIS OF LEFT HIP REPLACEMENT, REQUIRE SN TO ASSESS INTEG SYSTEM/VITAL SIGN (S) AND REPORT CHANGES TO PHYSICIAN.

HOME HEALTH AGENCY MAY ACCEPT ORDERS FROM THE FOLLOWING PHYSICIANS: DR MCCARTHY AND OTHER CONSULTING PROVIDERS

I certify 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 will periodically review the plan. I further certify that this patient had a Face-to-Face Encounter performed by a physician or allowed non-physician practitioner that was related to the primary reason the patient requires Home Health services on 05/16/2025.

Attending Physician's Signature and Date Signed

Electronically Signed by [ ] on [ ]

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.

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
100201839287	5/17/2025	5/17/2025 to 7/15/2025	C0200241665301	227203

Patient's Name	Provider's Name
RUSSELL A BOLTON	ACCENTCARE OF MASS, INC. DBA AC HH OF MASS

Orders of Discipline and Treatments:

SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY UNTOWARD CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY, NUTRITION, MEDICATION REGIMEN, INFECTION CONTROL MEASURES, AND PRESSURE ULCER PREVENTION. SN TO REPORT SIGNIFICANT CHANGES IN STATUS TO PHYSICIAN FOR EARLY INTERVENTION

SKILLED NURSE, PATIENT OR CAREGIVER TO PERFORM/TEACH WOUND CARE AND INFECTION CONTROL MEASURES TO INCISION/SUTURE SITE LOCATED LEFT HIP SURGICAL INCISION: LEAVE PICO DRESSING IN PLACE UNTIL FOLLOW UP APPT 5/28. MAY DISCONTINUE WOUND CARE WHEN WOUND CLOSED OR HEALED.

MAY USE THE FOLLOWING PROTOCOL AS AN ALTERNATE DRESSING AS NEEDED IF THE ABOVE WOUND TREATMENT SUPPLIES ARE UNAVAILABLE IN THE HOME: CLEANSE WITH NORMAL SALINE OR WOUND CLEANSER, PAT DRY, COVER WITH DRY STERILE DRESSING AND SECURE WITH TAPE OR GAUZE. MAY DC WOUND CARE WHEN WOUND IS HEALED. MAY OBTAIN WOUND C&S PRN S/SX OF INFECTION.ALLOW 3 PRN SN VISITS TO ASSESS REPORTS OF CHANGES IN THE WOUND THAT WOULD INDICATE INFECTION SUCH AS REDNESS, SWELLING, PAIN, ABNORMAL DISCHARGE, ODOR, ABNORMAL GRANULATION TISSUE OR FEVER; TO REAPPLY DRESSING; TO EVALUATE A MALFUNCTION IN EQUIPMENT SUCH AS WOUND VAC OR SUPPORT SURFACE. MAY OBTAIN WOUND CULTURE PRN S/SX OF INFECTION.

SKILLED NURSE FOR OBSERVATION AND ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT, FALLS, MEDICATION REGIMEN, HOSPITALIZATION RISK. SKILLED NURSE TO INTERVENE WITH INCREASED PAIN LEVEL TO MINIMIZE COMPLICATIONS. SN MAY OBTAIN URINE DIPSTICK PRN FOR S/S UTI.

SN TO ASSESS FOR AND IDENTIFY PATIENT'S RISK FOR HOSPITALIZATION R/T LEFT THR AND INSTRUCT ON MANAGING HOSPITALIZATION RISK R/T ANY CONDITION(S) OF DECLINE IN MENTAL, EMOTIONAL, OR BEHAVIORAL STATUS IN THE PAST 3 MONTHS; REPORTED /OBSERVED HISTORY OF DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS; HIGH RISK MEDICATIONS.

SN FOR OBSERVATION/ASSESSMENT AND INSTRUCTION ON DIABETES TO INCLUDE: DIET, SKIN CARE, FOOT CARE, MONITORING INCLUDING HGBA1C, MEDICATION MANAGEMENT, AND HYPOGLYCEMIC INTERVENTION. NO ORDERS TO CHECK BG.

SKILLED NURSE TO PROVIDE SKILLED TEACHING IN THE DISEASE PROCESS AND MEDICATION REGIMEN OF HYPERTENSION.

SKILLED NURSE TO INSTRUCT/REINFORCE REGARDING INFECTION CONTROL MEASURES. SKILLED NURSE TO O/A PATIENT FOR SIGNS AND SYMPTOMS OF INFECTION INCLUDING BUT NOT LIMITED TO: DEFICIENT IMMUNOLOGIC DEFENSES AND ENVIRONMENTAL FACTORS Q VISIT. TEACH WHERE DEFICITS ARE IDENTIFIED.

PHYSICAL THERAPIST TO EVALUATE/ASSESS AND DEVELOP PHYSICAL THERAPY PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN. MAY COMPLETE A ROC ASSESSMENT UPON HOSPITAL DISCHARGE DURING THIS EPISODE IF NEEDED. MAY SCHEDULE A BH RN EVALUATION AS NEEDED DURING THE EPISODE TO ASSESS FOR IMPACT OF BEHAVIOR, MEDICATIONS AND/OR NEED FOR FOLLOW-UP. MAY INITIATE TELEHEALTH OR REMOTE TELEMONITORING VISITS AS NEEDED, FOLLOW AGENCY PARAMETERS FOR REPORTING UNLESS OTHERWISE SPECIFIED. MAY CONSULT SOCIAL WORKER FOR ADVANCED CARE PLANNING, GOALS OF CARE, AND PATIENT ADVOCACY. MAY PERFORM O2 SATURATION LEVEL AT EVALUATION VISIT AND PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS OR WITH O2 USE AND NOTIFY MD OF O2 LEVELS BELOW 92.PHYSICAL THERAPY TO PROVIDE INTERVENTIONS FOR THE TREATMENT OF LEFT TOTAL HIP REPLACEMENT ACCORDING TO RIGHTPATH PROGRAM FOR JOINT REHABILITATION INCLUDING BUT NOT LIMITED TO RANGE OF MOTION, STRENGTHENING, GAIT, BALANCE, TRANSFER TRAINING. PHYSICAL THERAPY TO PROVIDE PHARMACOLOGIC AND NON-PHARMACOLOGIC PAIN MANAGEMENT INCLUDING MANUAL THERAPY AND/OR ICE AS ORDERED BY PROVIDER, AND MEDICATION MANAGEMENT INCLUDING MONITORING EFFECTIVENESS OF DRUG THERAPY, REACTIONS, SIDE EFFECTS AND REPORTING PROBLEMS. PT TO CONTACT PHYSICIAN TO RESOLVE CLINICALLY SIGNIFICANT MEDICATION ISSUES INCLUDING RECONCILIATION. PT TO APPLY AND/OR INSTRUCT PATIENT/CG TO APPLY ICE TO LEFT HIP FOR 20MINS ON/OFF

THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS ON THIS POC ATTESTS THAT THE PHYSICIAN'S ORDERS WERE RECEIVED ON 5/17/2025.

LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FALLING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS. TEMP<96>100.3 PULSE<60>110 RESP<10>26 SYSTOLICBP<90>160 DIASTOLICBP<50>100 WEIGHT<205>215 PAIN>7 O2SAT<92

Goals/Rehabilitation Potential/Discharge Plans:

PATIENT WILL PARTICIPATE IN DEVELOPMENT AND UPDATING OF PLAN OF CARE TO MEET ALL PHYSICAL AND PSYCHOSOCIAL NEEDS.
ADDITIONAL ORDERS WILL BE RECEIVED FROM ALTERNATE PHYSICIAN IN A TIMELY MANNER.
CHANGES IN SKIN INTEGRITY STATUS WILL BE IDENTIFIED AND REPORTED TO THE PHYSICIAN FOR PROMPT INTERVENTION.
PATIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE ADEQUATE KNOWLEDGE OF INTEGUMENTARY STATUS AEB VERBALIZATION/DEMONSTRATION OF 2 MEASURES TO PROMOTE SKIN INTEGRITY AND PREVENT INJURY BY 3WEEKS.
PATIENT/CAREGIVER WILL DEMONSTRATE ABILITY TO PERFORM ORDERED WOUND CARE. WOUND STATUS WILL IMPROVE AS EVIDENCED BY A DECREASE IN SIZE BY DRAINAGE, ABSENCE OF INFECTION, AND DECREASED PAIN BY 3 WEEKS

Signature of Physician	Date
Electronically Signed by [ ] on [ ]	
Optional Name/Signature Of JENNA-MAE ARRUDA, RN / LISA COUGHLIN RN	Date 5/17/2025

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Patient's Name	Provider's Name
RUSSELL A BOLTON	ACCENTCARE OF MASS, INC. DBA AC HH OF MASS

Goals/Rehabilitation Potential/Discharge Plans:

INCREASED PAIN OR INADEQUATE PAIN CONTROL MEASURES WILL BE IDENTIFIED AND PROMPTLY REPORTED TO THE PHYSICIAN.
PATIENT/CAREGIVER WILL VERBALIZE 3-5 EDUCATION POINTS RELATED TO UNDERSTANDING OF PHARMACOLOGIC AND NON-PHARMACOLOGIC PAIN CONTROL MEASURES WITHIN 3 WEEKS
PATIENT/CAREGIVER WILL BE ABLE TO VERBALIZE THEIR RISK FACTORS FOR HOSPITALIZATIONS AND APPROPRIATE STEPS TO REDUCE RISKS WITHIN 3 WEEKS.
PATIENT/CAREGIVER WILL DEMONSTRATE 3-5 APPROPRIATE MEASURES RELATED TO MANAGEMENT OF DIABETIC CARE BY 3 WEEKS
PATIENT/CAREGIVER WILL VERBALIZE 3-5 RISK FACTORS, S/S AND CAUSES OF HYPERTENSION AND WILL DEMONSTRATE ABILITY TO TAKE/MONITOR BLOOD PRESSURE AND KNOWLEDGE OF WHEN MD INTERVENTION IS NEEDED BY 3 WEEKS.
CAREGIVER WILL VERBALIZE 3-5 APPROPRIATE INFECTION CONTROL MEASURES TO PREVENT INFECTION OR CONTAMINATION AND PATIENT WILL EXHIBIT NO SIGNS / SYMPTOMS OF INFECTION OR SIGNS AND SYMPTOMS OF INFECTION WILL BE IDENTIFIED AND PHYSICIAN NOTIFIED FOR PROMPT INTERVENTION TO MINIMIZE ASSOCIATED RISKS BY 3 WEEKS.

A PHYSICAL THERAPY PLAN OF CARE WILL BE ORDERED BY PHYSICIAN AND PROVIDED BY PHYSICAL THERAPY. ALL GOALS TO BE MET BY END OF CURRENTLY APPROVED PLAN OF CARE.
PATIENT WILL DEMONSTRATE IMPROVEMENT IN TOLERANCE AND INDEPENDENCE TO FUNCTIONAL ACTIVITY AS OUTLINED BY THE OBJECTIVE MEASUREMENTS IN THERAPY SHORT TERM/LONG TERM GOALS BY THE DOCUMENTED GOAL DATES AS EVIDENCED BY DECREASED ASSISTANCE NEEDED.

PATIENT/CAREGIVER WILL VERBALIZE EFFECTIVE PAIN CONTROL AND UNDERSTAND BOTH PHARMACOLOGIC AND NON-PHARMACOLOGIC PAIN CONTROL METHODS AS EVIDENCED BY PATIENT VERBALIZING DECREASE IN PAIN TO ACCEPTABLE LEVELS IN ORDER TO COMPLETE MOBILITY AND FUNCTION BY 8 WEEKS.

PATIENT/CAREGIVER WILL RECEIVE MEDICATION MANAGEMENT AND PHYSICIAN WILL BE CONTACTED WITHIN ONE CALENDAR DAY OF THE ASSESSMENT TO RESOLVE CLINICALLY SIGNIFICANT MEDICATION ISSUES, INCLUDING RECONCILIATION.

Rehab Potential:

GOOD/MARKED IMPROVEMENT IN FUNCTIONAL STATUS IS EXPECTED

DC Plans:

PATIENT WILL DISCHARGE TO FAMILY/CAREGIVER OR SELF UNDER THE SUPERVISION OF PCP.
D/C SUMMARY TO BE SENT TO PCP. AGENCY MAY DISCHARGE EARLY IF GOALS MET OR PER PT REQUEST.

DME and Supplies:

ALCOHOL, GLOVES, VITAL SIGN EQUIPMENT; CLINICAL TOOLS; DME-ADAPTIVE LIVING AIDS; DME-CANE; DME-ELEVATED TOILET SEAT; DME-RAILS/GRAB BARS; DME-SHOWER/TUB EQUIPMENT; DME-WALKER ; INFECTION CONTROL SUPPLIES; THERAPY SUPPLIES; WOUND CARE SUPPLIES

Prognosis:

GOOD

Functional Limitations:

TOTAL HIP PRECAUTIONS; WOUND; DYSPNEA; AMBULATION, ENDURANCE, FALL RISK, PAIN

Safety Measures:

ALERT YOUR NURSE , FALL PRECAUTIONS, EMERGENCY PREPAREDNESS PLAN DEVELOPED USING AGENCY ZONE TOOL, MEDICATION PRECAUTIONS, UNIVERSAL PRECAUTIONS, HIP PRECAUTIONS, WOUND PRECAUTIONS, INFECTION CONTROL PRECAUTIONS, DISPOSAL OF MEDICAL WASTE, CARDIAC PRECAUTIONS, DIABETIC PRECAUTIONS, HYPO/HYPERGLYCEMIA PRECAUTIONS, DIABETIC FOOT PRECAUTIONS, ASA BLEEDING PRECAUTIONS

Activities Permitted:

UP AS TOLERATED; WALKER; CANE; ASSIST TO LEAVE HOME, EXERCISES PRESCRIBED, ADL/IADL ASSISTANCE

Nutritional Requirements:

CARDIAC DIET, DIABETIC DIET

Advance Directives:

NONE

Mental Statuses:

ORIENTED

Signature of Physician	Date
Electronically Signed by [ ] on [ ]	
Optional Name/Signature Of JENNA-MAE ARRUDA, RN / LISA COUGHLIN RN	Date 5/17/2025

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RUSSELL A BOLTON	ACCENTCARE OF MASS, INC. DBA AC HH OF MASS

Supporting Documentation for Cognitive Status:

(C1) (QM) (PRA) (M1700) COGNITIVE FUNCTIONING: PATIENT'S CURRENT (DAY OF ASSESSMENT) LEVEL OF ALERTNESS, ORIENTATION, COMPREHENSION, CONCENTRATION, AND IMMEDIATE MEMORY FOR SIMPLE COMMANDS.

0 - ALERT/ORIENTED, ABLE TO FOCUS AND SHIFT ATTENTION, COMPREHENDS AND RECALLS TASK DIRECTIONS INDEPENDENTLY.

(QM) (M1710) WHEN CONFUSED (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:

0 - NEVER

(QM) (M1720) WHEN ANXIOUS (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:

0 - NONE OF THE TIME

(C1) (QM) (PRA) (M1740) COGNITIVE, BEHAVIORAL, AND PSYCHIATRIC SYMPTOMS THAT ARE DEMONSTRATED AT LEAST ONCE A WEEK (REPORTED OR OBSERVED): (MARK ALL THAT APPLY.)

7 - NONE OF THE ABOVE BEHAVIORS DEMONSTRATED

Supporting Documentation for Psychosocial Status:

(C1) (QM) (PRA) (M1700) COGNITIVE FUNCTIONING: PATIENT'S CURRENT (DAY OF ASSESSMENT) LEVEL OF ALERTNESS, ORIENTATION, COMPREHENSION, CONCENTRATION, AND IMMEDIATE MEMORY FOR SIMPLE COMMANDS.

0 - ALERT/ORIENTED, ABLE TO FOCUS AND SHIFT ATTENTION, COMPREHENDS AND RECALLS TASK DIRECTIONS INDEPENDENTLY.

(QM) (M1710) WHEN CONFUSED (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:

0 - NEVER

(QM) (M1720) WHEN ANXIOUS (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:

0 - NONE OF THE TIME

(C1) (QM) (PRA) (M1740) COGNITIVE, BEHAVIORAL, AND PSYCHIATRIC SYMPTOMS THAT ARE DEMONSTRATED AT LEAST ONCE A WEEK (REPORTED OR OBSERVED): (MARK ALL THAT APPLY.)

7 - NONE OF THE ABOVE BEHAVIORS DEMONSTRATED

Supporting Documentation for Risk of Hospital Readmission:

(PRA) (M1033) RISK FOR HOSPITALIZATION: WHICH OF THE FOLLOWING SIGNS OR SYMPTOMS CHARACTERIZE THIS PATIENT AS AT RISK FOR HOSPITALIZATION? (MARK ALL THAT APPLY.)

5 - DECLINE IN MENTAL, EMOTIONAL, OR BEHAVIORAL STATUS IN THE PAST 3 MONTHS || 6 - REPORTED OR OBSERVED HISTORY OF DIFFICULTY COMPLYING WITH ANY MEDICAL INSTRUCTIONS (FOR EXAMPLE, MEDICATIONS, DIET, EXERCISE) IN THE PAST 3 MONTHS || 7 - CURRENTLY TAKING 5 OR MORE MEDICATIONS || 8 - CURRENTLY REPORTS EXHAUSTION || 9 - OTHER RISK(S) NOT LISTED IN 1 - 8

Allergies:

NKA

Signature of Physician	Date
Electronically Signed by [ ] on [ ]	
Optional Name/Signature Of JENNA-MAE ARRUDA, RN / LISA COUGHLIN RN	Date 5/17/2025

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Medications:

Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
ASPIRIN 325 MG TABLET		ORAL			
1 tablet	*2 TIMES DAILY*				
Reason: BLOOD THINNER					
Instructions:					
CEFADROXIL 500 MG CAPSULE		ORAL			
1 capsule	*2 TIMES DAILY*		05/22/2025		
Reason: PREVENT INFECTION					
Instructions:					
CELECOXIB 200 MG CAPSULE		ORAL			
1 capsule	*2 TIMES DAILY*				
Reason: DECREASE INFLAMMATION					
Instructions: 1 TAB 2 TIMES A DAY FOR ONE WEEK THEN 1 TIME A DAY AS NEEDED FOR INFLAMMATION					
DOCUSATE SODIUM 100 MG CAPSULE		ORAL			
1 capsule	*2 TIMES DAILY*				
Reason: STOOL SOFTNER					
Instructions:					
METFORMIN ER 500 MG TABLET,EXTENDED RELEASE 24 HR		ORAL			
1 tablet	*TWICE DAILY*				
Reason: LOWER BLOOD SUGAR					
Instructions: PATIENT IS NOT ORDERED TO CHECK BLOOD SUGARS. 1AC IS MONITORED BY PCP					
ROSUVASTATIN 5 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: CHOLESTEROL					
Instructions:					
TRAMADOL 50 MG TABLET		ORAL			
1-2 tablet	*EVERY 6 HOURS/PRN*				
Reason: SEVERE PAIN 7-10					
Instructions:					

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Supporting Documentation for Home Health Eligibility:

THE FOLLOWING BODY STRUCTURES EITHER REQUIRE HOME HEALTH INTERVENTION OR WILL IMPACT THE HOME HEALTH PLAN OF CARE:

SKIN AND RELATED STRUCTURES, STRUCTURES OF THE CARDIOVASCULAR SYSTEM, STRUCTURES RELATED TO MOVEMENT, STRUCTURES RELATED TO THE METABOLIC AND ENDOCRINE SYSTEMS

THE FOLLOWING BODY SYSTEM FUNCTIONS EITHER REQUIRE HOME HEALTH INTERVENTION OR WILL IMPACT THE HOME HEALTH PLAN OF CARE:
FUNCTIONS OF THE CARDIOVASCULAR SYSTEM, FUNCTIONS OF THE METABOLIC AND ENDOCRINE SYSTEMS, FUNCTIONS OF THE SKIN AND RELATED STRUCTURES, NEUROMUSCULOSKELETAL AND MOVEMENT-RELATED FUNCTIONS, SENSORY FUNCTIONS AND PAIN

(HOMEBOUND STATUS CRITERIA 1A AND 1B) BECAUSE OF ILLNESS OR INJURY, THE PATIENT NEEDS SUPPORTIVE DEVICES, SPECIAL TRANSPORTATION, ASSISTANCE OF ANOTHER PERSON AND/OR LEAVING THE HOME IS MEDICALLY CONTRAINDICATED DUE TO:
RISK OF INFECTION OR IMMUNOCOMPROMISED STATUS, THE PATIENT REQUIRES ASSISTANCE AND/OR SUPERVISION OF ANOTHER PERSON(S) TO PERFORM ADL/IADL AND SELF-CARE TASKS SAFELY., THE PATIENT REQUIRES ASSISTANCE AND/OR SUPERVISION OF ANOTHER PERSON(S) TO PERFORM SAFE AMBULATION/LOCOMOTION ON EVEN AND UNEVEN SURFACES., THE PATIENT REQUIRES ASSISTANCE AND/OR SUPERVISION OF ANOTHER PERSON(S) TO PERFORM SAFE BED MOBILITY AND TRANSFERS., THE PATIENT REQUIRES ASSISTANCE AND/OR SUPERVISION OF ANOTHER PERSON(S) TO PERFORM SAFE TRANSFER FROM SIT TO STAND., THE PATIENT REQUIRES ASSISTANCE OF A WALKER TO SAFELY LEAVE THE HOME, THE PATIENT REQUIRES ASSISTANCE OF CANE TO SAFELY LEAVE THE HOME

(HOMEBOUND STATUS CRITERIA 2A AND 2B) THE PATIENT HAS A NORMAL INABILITY TO LEAVE THE HOME AND LEAVING THE HOME REQUIRES A CONSIDERABLE AND TAXING EFFORT DEMONSTRATED BY:
PATIENT CANNOT INDEPENDENTLY MANAGE NECESSARY MEDICAL EQUIPMENT AND REQUIRES MAXIMUM OR TOTAL ASSIST IN ORDER TO LEAVE THE HOME, PATIENT EXPERIENCES ACTIVITY LIMITING PAIN LEVEL WITH TRANSFERS AND WEIGHT BEARING ACTIVITIES, PATIENT HAS CONSIDERABLE WEAKNESS THAT LIMITS SAFE TRANSFER AND/OR AMBULATION OUTSIDE THE HOME, PATIENT HAS INCREASED FALL RISK BECAUSE OF POOR BALANCE AND/OR FUNCTIONAL MOBILITY WHEN LEAVING THE HOME ENVIRONMENT, PATIENT IS UNABLE TO NEGOTIATE STAIRS AND/OR UNEVEN SURFACES IN AND OUT OF HOME SAFELY DUE TO WEIGHT BEARING RESTRICTION, WEAKNESS OR BALANCE IMPAIRMENTS, PATIENT REQUIRES FREQUENT REST PERIODS WHEN AMBULATING DUE TO ENDURANCE LIMITATION AND DECREASED SAFETY, POOR BALANCE WITH WEIGHT BEARING ACTIVITIES AND IS A FALL RISK FOR TRANSFER AND/OR AMBULATION OUTSIDE THE HOME

THE PHYSICIAN CERTIFIES BY SIGNING BELOW THAT THIS DOCUMENT AND ITS CONTENTS HAVE BEEN INCORPORATED INTO THE PHYSICIAN'S MEDICAL RECORD AND MAY BE USED TO SUPPORT HOMEBOUND STATUS AND MEDICAL NECESSITY FOR CARE.

A DISCHARGE SUMMARY WILL BE PROVIDED.
.

PRIOR TO THIS SPELL OF ILLNESS, THE PATIENT'S OVERALL FUNCTION AND/OR COGNITIVE ABILITIES REQUIRED:
NO ASSISTANCE WITH ADL/IADL AND SELF-CARE TASKS.

Therapy Short Term/Long Term Goals:

Discipline: PT

BALANCE (PT)

TINETTI

STG: 18	LTG: 21
TARGET DATE: 6/20/2025	TARGET DATE: 7/11/2025

GAIT (PT)

STAIRS ASCENDING ASSISTANCE

STG: STANDBY ASSIST	LTG: MODIFIED INDEPENDENT
TARGET DATE: 6/20/2025	TARGET DATE: 6/27/2025

STAIRS DESCENDING ASSISTANCE

STG: STANDBY ASSIST	LTG: MODIFIED INDEPENDENT
TARGET DATE: 6/20/2025	TARGET DATE: 6/27/2025

RIGHTPATH PROGRAM FOR JOINT REPLACEMENT (LEFT HIP) (PT)

ROM - LEFT HIP FLEXION

STG: 90	LTG:
TARGET DATE: 6/27/2025	TARGET DATE:

ROM - LEFT HIP ABDUCTION

STG: 40	LTG:

Signature of Physician	Electronically Signed by [ ] on [ ]	Date
Optional Name/Signature Of JENNA-MAE ARRUDA, RN / LISA COUGHLIN RN		Date 5/17/2025

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Therapy Short Term/Long Term Goals:

Discipline: PT

RIGHTPATH PROGRAM FOR JOINT REPLACEMENT (LEFT HIP) (PT)

ROM - LEFT HIP ABDUCTION

TARGET DATE: 6/27/2025	TARGET DATE:

PAIN (WORST IN PREVIOUS 24 HOUR PERIOD) - LEFT HIP

STG: 1	LTG:
TARGET DATE: 6/27/2025	TARGET DATE:

PAIN (LOWEST IN PREVIOUS 24 HOUR PERIOD) - LEFT HIP

STG: 0	LTG:
TARGET DATE: 6/20/2025	TARGET DATE:

ASSISTIVE DEVICE

STG: CANE/SINGLE SUPPORT	LTG: SUPERVISION ONLY (NO AD)
TARGET DATE: 6/20/2025	TARGET DATE: 6/27/2025

DISTANCE AMBULATED (FEET)

STG: 76-100 FT	LTG: 126-150 FT
TARGET DATE: 6/20/2025	TARGET DATE: 6/27/2025

Signature of Physician	Date
Electronically Signed by [ ] on [ ]	
Optional Name/Signature Of JENNA-MAE ARRUDA, RN / LISA COUGHLIN RN	Date 5/17/2025