Home Health Certification and Plan of Care

Order ID: 1150/11663

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
94288771	08/21/2025	From: 08/21/2025 To: 10/19/2025	2651	217058

6. Patient's Name and Address
Claude Kakira
5307 Moravia Rd Apt. C,
BALTIMORE, MD 21206-
443-831-2172

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 01/01/1996 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	08/21/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	08/21/25
Q65.89	Other specified congenital deformities of hip	08/21/25
Z79.82	Long term (current) use of aspirin	08/21/25

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

Cialis - Tadalafil 20mg oral, take 1 tablet by mouth once a day As needed 1 hour before sexual activity
Ibuprofen - Ibuprofen 600 mg 1 tab by mouth every 6 hours inflammation and pain
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 mg 1-2Tabs by mouth every 4 hours pain
Asa - Aspirin 81 mg by mouth twice a day blood clot prevention 8/21/25- to be taken twice a day for 4 weeks
Docusate Sodium - Docusate Sodium 100 MG CAP 1 cap by mouth twice a day constipation Patient understood how to take the medicines and its purpose.

14. DME and Supplies:
rolling walker, hospital bed

15. Safety Measures:
infectious material management, walker precautions, medication safety, fall precautions, ambulates with device, supervision at all times, hip precautions, ambulates with assistance, standard precautions, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance, language barrier

18.B. Activities Permitted
Walker, Up As Tolerated, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, 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
family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: After undergoing Left 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.

Clinical Condition Requiring Homecare:

The patient is a 29-year-old African American male with a past medical history significant for osteoarthritis and leg length discrepancy, status post recent left total hip replacement. His surgical history includes a prior right total hip replacement. The patient was evaluated in the home setting and was found lying in bed with an ice pack placed over the left hip. He is alert and oriented, though he has limited English proficiency and primarily speaks Kinyarwanda. Due to the language barrier and absence of an interpreter in the home, his cousin, Paul, was contacted by phone at work to assist with communication. On examination, the left hip incision measured approximately 33 cm, with dressing intact and no drainage observed. Surrounding skin was very warm to touch. Vital signs revealed a temperature of 101.7F, pulse 131 bpm, respirations 20 per minute, and blood pressure 134/81 mmHg. The patient reported hip pain rated at 7/10. He was instructed to take ibuprofen, eat a meal, and drink water for hydration. Dr. Huang was notified and provided orders for the patient to take acetaminophen and increase oral fluid intake, with instructions to proceed to urgent care if the fever did not decrease within one hour. Because the patient is under the surgical care of Dr. Narcisse, follow-up communication was made with Dr. Narcisse's office. The message was relayed to his staff, with Stephanie documenting the patient's condition and providing the supervising nurse's contact number for updates. Medication reconciliation was performed by reviewing the medication list in the computer alongside the bottles available in the home. Pain medications were appropriately labeled. The patient was unable to locate his discharge papers, which could not be found by the visiting nurse due to multiple large bags on the table. The patient's cousin was contacted and agreed to send a picture of the discharge papers to the nurse later the same day. Admission documents were reviewed with the patient, explained, and signed. From a functional perspective, the patient currently ambulates approximately 30 feet on indoor surfaces with the assistance of a rolling walker and requires supervision. He needs frequent cues for gait correction, particularly to flatten the left foot and initiate stance with heel strike. Bed mobility requires moderate assistance, while transfers to bed or chair require minimal assistance. Stairs, outdoor ambulation, and car transfers were not assessed during this visit. The patient resides with his brother in a basement apartment, which requires navigating four steps with a handrail for entry. His Tinetti score of 11/28 confirms a high fall risk and supports homebound status due to significant effort required to leave the home, even with assistive devices and assistance. The patient participated in a therapeutic exercise program consisting of 10 repetitions each of quadriceps sets, gluteal sets, hip flexion, bridging, knee extensions, and ankle pumps, which he tolerated well. He would benefit from continued skilled home physical therapy services focused on improving strength, hip mobility, functional mobility, and gait training to promote independence and reduce fall risk. Ongoing skilled nursing is also indicated to monitor post-operative healing, fever, and pain control, as well as to provide education on medication management, hydration, and recognition of signs requiring urgent medical attention such as persistent fever, wound drainage, or increased hip pain. The patient and his support system verbalized understanding of the plan of care.
 Date of Order 08/21/2025 Orders Physician Face-to-Face Date: 08/04/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left Total Hip 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: PT Eval Notes: Physician Narcisse, Patrick

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles SN RN on 08/21/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
Patrick Narcisse
2391 Greenspring Dr
Timonium , MD 21093
PHONE: 410-847-3000 FAX: NPI: 1508397092

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 : 08/04/2025

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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SN WK1: 1 (08/21/25-08/23/25) ,WK2: 1 (08/24/25-08/30/25)

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, 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; 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 the pt's incision and on post op day 12-14 the nurse or physical therapist will remove the patient's staples and leave OTA., 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)

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, Home Safety, meal preparation, M1400 - Dyspnea, erectile dysfunction, muscle weakness, limited range of motion, limited strength, limited endurance, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Left Hip -

PROCEDURES: Discharge from Skilled Nursing- Do DISCHARGE SUMMARY- SN communication note, Medication Review-: Medications reviewed with patient/caregiver., cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: To left hip surgical site- 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.

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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered, meal preparation is available to patient for all meals

PATIENT-STATED GOAL: to walk without pain

GOALS
patient's living environment is clean/uncluttered

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

meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (08/21/25-08/23/25) ,WK2: 3 (08/24/25-08/30/25) ,WK3: 2 (08/31/25-09/06/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Effect on Sleep, GG0170I1 - Walk 10 Feet, GG0130A1 - Eating, GG0170P1 - Picking Up Object, 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, GG0130B1 - Oral Hygiene, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing

PROCEDURES: Home exercise program : Glut sets, quad sets, hip flexion, bridging. Standing knee flet,hip abduction, plantarflexion, squats. Sitting knee extension, ankle pumps , Bed mobility training , Hip precautions training, Medication Review- : Medications reviewed with patient/caregiver., equipment training, gait training on uneven surfaces,

PT Goals

PATIENT-STATED GOAL: To be able to walk without a limp without my crutches

GOALS
Toilet Transfer - 06. Independent

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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles SN RN

Date
08/21/2025

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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, Oral Hygiene - 06. Independent, Lower Body Dressing - 03. Partial/moderate assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 05. Setup or clean-up assistance, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 06. Independent, Car Transfer - 04. Supervision or touching 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, Medication Review-

Shower/Bathe Self - 03. Partial/moderate assistance

Car Transfer - 04. Supervision or touching assistance

Picking Up Object - 05. Setup or clean-up assistance

Medication Review-

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 05. Setup or clean-up assistance

Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

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

Signature of Physician:	Date
	PAGE 3 of 3
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