# Home Health Certification and Plan of Care

**Order ID: 1150/12356**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 981167819 | 09/19/2025 | From: 09/19/2025 To: 11/17/2025 | 17046 | 217058 |

**6. Patient's Name and Address**
John Hawkins
1118 Myrtle Ave,
BALTIMORE, MD 21201-
410-907-1129

**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** 06/21/1963 | **9.Sex** Male

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| Z47.1 | Aftercare following joint replacement surgery | 09/19/25 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| Z96.641 | Presence of right artificial hip joint | 09/19/25 |
| M16.12 | Unilateral primary osteoarthritis left hip | 09/19/25 |
| I10. | Essential (primary) hypertension | 09/19/25 |
| M19.011 | Primary osteoarthritis right shoulder | 09/19/25 |
| H26.9 | Unspecified cataract | 09/19/25 |
| H04.123 | Dry eye syndrome of bilateral lacrimal glands | 09/19/25 |
| D31.02 | Benign neoplasm of left conjunctiva | 09/19/25 |
| D31.01 | Benign neoplasm of right conjunctiva | 09/19/25 |
| H18.413 | Arcus senilis bilateral | 09/19/25 |
| H43.819 | Vitreous degeneration unspecified eye | 09/19/25 |
| E55.9 | Vitamin D deficiency unspecified | 09/19/25 |
| E78.5 | Hyperlipidemia unspecified | 09/19/25 |
| R73.03 | Prediabetes | 09/19/25 |
| E66.9 | Obesity unspecified | 09/19/25 |
| Z68.31 | Body mass index [BMI] 31.0-31.9 adult | 09/19/25 |

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

Lidocaine - Lidocaine 4 % Top PTMD Patch/Apply 1 patch topical every 12 hours Apply 1 patch to skin daily . May keep patch in place for up to 12 hours in a 24-hour period
Atorvastatin - Atorvastatin Calcium 20 mg Oral Tab/Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for cholesterol and heart protection
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 4 hours For pain
Extra Strength Tylenol - Acetaminophen 650mg by mouth every 6 hours For inflammation
Colace - Docusate Sodium 100mg by mouth twice a day Stool softeners
Aspirin - Aspirin 81mg by mouth twice a day prevention for heart disease
Losartan Potassium And Hydrochlorothiazide - Hydrochlorothiazide: Losartan Potassium 50-12.5 mg Oral Tab/Take 1 tablet by mouth once a day manage elevated blood pressure

**14. DME and Supplies:**
walker, cane

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

**16. Nutrition:**
low sodium, low cholesterol

**17. Allergies:**
no known allergies

**18.A. Functional Limitations**
Ambulation, Endurance

**18.B. Activities Permitted**
Walker, Cane, Up As Tolerated

**19. Mental & Pyschosocial 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

**20. Prognosis:** good

**22. A 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.

**22.B.Discharge Plans**
patient will be responsible for managing treatment

**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.

**Clinical Condition Requiring Homecare:** The patient is a 63-year-old male with a past medical history of hypertension, hyperlipidemia, and osteoarthritis who is status post right total hip replacement on 09/18/2025, performed by Dr. Narcisse. He is a funeral director by profession and currently resides at home, where he is considered homebound due to the taxing effort required to leave his residence, as evidenced by a Tinetti score of 14/28 indicating fall risk. On evaluation, the patient was alert and oriented 4, reporting right hip pain at 3/10, well controlled with current medication and non-pharmacological interventions. He ambulates indoors with a rolling walker approximately 30 feet 2 with supervision and cueing for step-to pattern, and is able to perform 14 steps with the use of a handrail and cane under supervision. Bed mobility, transfers to bed, chair, and raised toilet seat are completed with supervision, and hip precautions were reviewed with cueing. Gait remains unsteady but safe with use of assistive device, and no recent falls were reported. The surgical dressing was clean, dry, and intact with no drainage noted, though moderate swelling was observed; no other wounds were identified. The patient denies abdominal discomfort, nausea, vomiting, or dysuria, reports a bowel movement two days ago, and maintains good appetite. Lungs were clear to auscultation, and incentive spirometer use along with deep-cough exercises were reviewed, with proper technique demonstrated. Therapeutic exercises included supine quad sets, gluteal sets, hip flexion, bridging, seated knee extension, and ankle pumps (10 reps each), all of which were well tolerated. Education was provided on hydration, dressing care (avoid soaking), use of NSAIDs, ice, and compression for swelling, as well as monitoring for abnormal bruising, bleeding, increased pain, or swelling, with instructions to notify the surgeon immediately if such changes occur. All medications were reviewed, including directions, actions, and side effects, with the patient verbalizing understanding. Plan includes continuation of skilled home physical therapy to increase strength, balance, and endurance to facilitate safe progression toward independence, reinforcement of hip precautions and pain management strategies, and follow-up with the orthopedic surgeon as scheduled. <br> Date of

**23. Signature and Date of Verbal SOC Where Applicable:**
Electronically Signed by Messick, Charles SN RN on 09/19/2025

**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 : 09/09/2025

**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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Order 09/19/2025 Orders Physician Face-to-Face Date: 09/09/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right 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 <br> 1 - SOC - SN Notes: soc PT Eval Notes: eval Physician Narcisse, Patrick

## SN Careplans

SN WK1: 1 (09/19/25-09/20/25) ,WK2: 1 (09/21/25-09/27/25)

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: 0. No assistance needed - patient is independent or does not have needs in this area

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.

s/p left hip joint replacement not to wet dressing. Nsaid ice and compression as instructed.; 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
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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.

## SN Goals

PATIENT-STATED GOAL: to walk without discomfort

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
* how to manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* low cholesterol dietary guidelines
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

| Signature of Physician: | Date |
|---|---|
| | PAGE 2 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles SN RN | 09/19/2025 |

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s/p right hip joint replacement dressing remove 7-day post-surgery dressing removed measure incision and photograph
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, swelling in the arms/legs, abnormal blood pressure, abn cholesterol > 200 mg/dL, limited endurance, limited strength, swelling of affected area, limited range of motion, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, obesity, #1 - Non-Observable Surgical Wound - Anterior Right Hip -

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: To right 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., coordinate/arrange preparation of missing meals

TEACH PATIENT/CAREGIVER: * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * 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, * low cholesterol dietary guidelines, 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, * how to manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, 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 Careplans

PT WK1: 1 (09/19/25-09/20/25) ,WK2: 3 (09/21/25-09/27/25) ,WK3: 2 (09/28/25-10/04/25)

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 : Supine quad sets, glut sets, hip flexion, bridging, hip abduction. Standing knee flexion, hip abduction, plantarflexion, squats. Sitting knee extension, ankle pumps, Hip precautions training, equipment training, gait training on uneven surfaces, 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 - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 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, 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

## PT Goals

PATIENT-STATED GOAL: Be able to walk by myself without pain

GOALS
Chair to Bed to Chair - 06. Independent

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

Lower Body Dressing - 06. Independent

Car Transfer - 06. Independent

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

Shower/Bathe Self - 03. Partial/moderate assistance

Oral Hygiene - 06. Independent

Eating - 06. Independent

Sit to Stand - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Walk 150 Feet - 05. Setup or clean-up assistance

| Signature of Physician: | Date |
|---|---|
| | PAGE 3 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles SN RN | 09/19/2025 |