Home Health Certification and Plan of Care

Order ID: 1150/12845

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
32301366	10/02/2025	From: 10/02/2025 To: 11/30/2025	17356	217058

6. Patient's Name and Address

Dean Scott
105 Lariat Rd,
ESSEX, MD 21221-
443-600-6480

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 03/31/1964 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	10/02/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	10/02/25
M47.26	Other spondylosis with radiculopathy lumbar region	10/02/25
I10.	Essential (primary) hypertension	10/02/25
E03.9	Hypothyroidism unspecified	10/02/25
F33.9	Major depressive disorder recurrent unspecified	10/02/25
M10.9	Gout unspecified	10/02/25
E78.5	Hyperlipidemia unspecified	10/02/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	10/02/25
G25.81	Restless legs syndrome	10/02/25
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	10/02/25
K76.0	Fatty (change of) liver not elsewhere classified	10/02/25
F41.9	Anxiety disorder unspecified	10/02/25
F10.21	Alcohol dependence in remission	10/02/25
Z87.442	Personal history of urinary calculi	10/02/25
Z85.818	Prsnl hx of malig neoplm of site of lip oral cav & pharynx	10/02/25
Z87.891	Personal history of nicotine dependence	10/02/25

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

Levothyroxine (LEVOTHROID/SYNTHROID) 175 mcg , Take 1 tablet by mouth in the morning Take 1 tablet by mouth every morning 30 minutes before a meal.
Lisinopril (PRINIVIL/ZESTRIL) 40 mg , Take 1 tablet by mouth once a day HTN
Atorvastatin (LIPITOR) 40 mg , Take 1 tablet by mouth once a day cholesterol and heart protection
Naloxone (NARCAN) 4 mg/actuation , Spray in 1 nostril if not breathing/responding. (Nasal Spray) Nasal as necessary Spray in 1 nostril if not breathing/responding. Call 911. If still not breathing/responding, use new spray in 2 to 3 minutes in other nostril. For suspected opioid overdose use only
Tylenol - Acetaminophen 500mg , Take 2 tablets by mouth every 6 hours As needed for Pain
Requip - Ropinirole Hydrochloride 1 mg , Take 3 tablets by mouth at bedtime For restless leg syndrome
Flomax - Tamsulosin Hydrochloride 0.4 mg , Take 2 capsules by mouth at bedtime
Zyloprim - Allopurinol 100 mg , Take 1 tablet by mouth once a day Gout
Ambien - Zolpidem Tartrate Take 5 mg tablet by mouth at bedtime As needed for Insomnia
Cymbalta - Duloxetine Hydrochloride 60 mg , Take 1 capsule by mouth once a day Depression
Zoloft - Sertraline Hydrochloride 100 mg , Take 1 tablet by mouth once a day Depression
Drisdol - Ergocalciferol 1,250 mcg (50,000 unit) , Take 1 capsule by mouth once a week Supplement
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, take 1 tablet by mouth every 4 hours As needed for pain
Colace - Docusate Sodium 100mg, take 1 capsule by mouth twice a day stool softner
Asa 81 Mg - Aspirin 81mg, take 1 tablet by mouth twice a day blood thinner

14. DME and Supplies:

bath bench, walker, cane

15. Safety Measures:

hip precautions, bathroom safety, , , infectious material management, , , activity supervision, aspiration precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

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: Yes

20. Prognosis: fair

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

patient will be responsible for managing treatment
another facility/provider will be responsible for managing treatment

Homebound status: After undergoing Right Total Hip Replacement, 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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 10/02/2025

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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Clinical Condition Requiring Homecare:

The patient is a 61-year-old male with a past medical history significant for major depressive disorder, hypertension, restless leg syndrome, and prior lumbosacral spine surgery. He is currently status post right total hip replacement (THR). The surgical site was observed to be covered with an intact Aquacel dressing, with no signs of drainage or infection noted. Vital signs were within normal limits, lung sounds were clear to auscultation bilaterally, and bowel sounds were active. The patient ambulates with the assistance of a rolling walker. During the skilled therapy session, the patient presented with severe right hip pain and postoperative edema. He was positioned supine and guided through a series of therapeutic exercises including heel slides and seated long arc quadriceps exercises (10 repetitions 2 sets), as well as standing activities such as single-leg marching and heel raises to promote strength, range of motion, and circulation. The patient was instructed in safe ambulation techniques using the rolling walker, with emphasis on maintaining a proper heel-to-toe gait pattern to improve balance and prevent compensatory movements. Comprehensive education was provided on pain management strategies, proper use of ice therapy to control swelling and discomfort, medication compliance including understanding uses and side effects, prevention of constipation, and monitoring for signs of infection at the surgical site. The patient demonstrated understanding of all instructions and was encouraged to continue the prescribed home exercise program to support recovery and improve functional mobility. The plan of care includes ongoing skilled nursing and physical therapy to monitor wound healing, manage pain and edema, reinforce safety during mobility, and facilitate progressive strengthening toward return to prior level of function.
 Date of Order 10/02/2025 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 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 Narcisse, Patrick

SN Careplans

SN WK1: 1 (10/02/25-10/04/25) ,WK2: 1 (10/05/25-10/11/25)

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, 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; 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.

; 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, abnormal thyroid <> 0.40 - 4.50 mIU/mL, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Hip -

PROCEDURES: Medication Review: Medication Reviewed by patient/caregiver., cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: Right hip surgical site: Remove Aquacel dressing on the 7th postoperative day and LOTA; otherwise, cover with dry gauze if drainage occurs.

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, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events,

SN Goals

PATIENT-STATED GOAL: To walk without 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

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

patient/caregiver recalls
* prescribed dietary modifications
* monitoring intake and output
* monitoring weight loss or weight gain
* monitor changes in neurological status
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* 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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	10/02/2025

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medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, * prescribed dietary modifications monitoring intake and output monitoring weight loss or weight gain monitor changes in neurological status, 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

PT Careplans

PT WK1: 1 (10/02/25-10/04/25) ,WK2: 3 (10/05/25-10/11/25) ,WK3: 2 (10/12/25-10/18/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, Pain Interference with ADLs, 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: Medication Review: The medication was reviewed with the patient , THR exercises: Heel slides, le abd/add, slr, l;ong arc , marching and heel raises --10x2 reps , cough/deep breathing exercises, incentive spirometer, equipment training, gait training on uneven surfaces, gait training/stair training, transfers training

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

PT Goals

PATIENT-STATED GOAL: To walk again with out pain

GOALS
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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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