# Home Health Certification and Plan of Care

**Order ID: 1150/13275**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 91319637 | 10/10/2025 | From: 10/10/2025 To: 12/08/2025 | 17702 | 217058 |

**6. Patient's Name and Address**
Ruby McGinnis
1533 Northbourne Rd,
Baltimore, MD 21239-
443-622-3077

**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** 01/20/1949 **9.Sex** Female

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

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| Z96.642 | Presence of left artificial hip joint | 10/10/25 |
| I10. | Essential (primary) hypertension | 10/10/25 |
| E66.9 | Obesity unspecified | 10/10/25 |
| Z68.37 | Body mass index [BMI] 37.0-37.9 adult | 10/10/25 |
| Z87.891 | Personal history of nicotine dependence | 10/10/25 |

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

Sodium Chloride (SALINE NASAL MIST) 0.65 % Nasl Aero Spray, Use 2 Sprays in each nostril Nasal as necessary Use 2 Sprays in each nostril as needed for nasal congestion (dryness of nose)
Aldactone - Spironolactone 25 mg , Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for HTN
Acetaminophen - Acetaminophen 500 MG , Take 2 tablets by mouth four times a day Taken for pain mgmt
Docusate Sodium - Docusate Sodium 100mg by mouth twice a day Taken for stool regimen
Aspirin - Aspirin 81mg by mouth twice a day Taken 2x daily
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 2000 iU by mouth once a day Supplement
Oxycontin - Oxycodone Hydrochloride 5 MG by mouth twice a day 1-2 tablets a day as needed for pain

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

**15. Safety Measures:**
hip precautions, , hand rails, , activity supervision

**16. Nutrition:**
Z. NO PHYSICIAN-ORDERED DIET

**17. Allergies:**
no known allergies

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

**18.B. Activities Permitted**
Exercises Prescribed, Walker, Cane, Partial Weight Bearing, Up As Tolerated

**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**
patient will be responsible for managing treatment

**Homebound status:** After undergoing Total Left 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.

**Clinical Condition Requiring Homecare:**
The patient is a 76-year-old female, alert, oriented 4, and cooperative during assessment. She was discharged home yesterday following a total left hip replacement due to osteoarthritis after conservative management, including steroid injections, failed to provide relief. Her past medical history includes osteoarthritis (OA) and hypertension (HTN). She currently resides alone in a townhouse with four steps at the entrance, and her bed and bathroom are located on the second floor. Her sister-in-law is temporarily staying with her to assist during the recovery period.  Upon assessment, the patient appeared in no acute distress, and vital signs were stable and within normal limits. The left hip incision was covered with an Aquacel dressing that was clean, dry, and intact. Per discharge orders, the dressing is to remain in place for seven days, after which the site may be left open to air if no drainage or signs of infection are present. The patient reports minimal pain at this time and has not required oxycodone. She ambulated safely indoors using a rolling walker for approximately 30 feet with supervision, demonstrating a steady but cautious gait. She can ascend and descend 14 stairs with the use of a railing and cane under supervision. Bed mobility requires minimal verbal cues, and transfers to bed, chair, and toilet are completed with supervision. Outdoor mobility and car transfers were not assessed during this visit.  The patient was educated on hip precautions, including avoidance of excessive hip flexion, internal rotation, and crossing of legs to prevent dislocation. She was instructed to apply ice to the surgical site for 20 minutes several times daily to reduce swelling and discomfort. Education was also provided on proper use of a home blood pressure monitor, including parameters for when to notify the physician of abnormal readings. The patient verbalized understanding of all teaching.  Physical therapy initiated a therapeutic exercise program consisting of supine quadriceps sets, gluteal sets, gentle hip flexion, bridging, seated knee extensions, and ankle pumps, 10 repetitions each, to promote circulation and muscle strength. She tolerated these exercises well without increased pain. Her Tinetti Balance and Gait Assessment score was 14/28, indicating a moderate fall risk and supporting her homebound status due to the taxing effort required to leave the home.  The patient will continue home health services for skilled nursing and physical therapy to monitor wound healing, reinforce hip precautions, and progress mobility and strengthening exercises. The registered nurse will return in seven days for dressing removal and wound evaluation. Ongoing goals include maintaining surgical site integrity, managing pain effectively, preventing falls, and improving strength and functional mobility for safe independence in the home. <br> Date of Order 10/10/2025 Orders Physician Face-to-Face Date: 09/26/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Total Left 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 <br> 1 - SOC - SN Notes: soc PT Eval Notes: eval Physician Narcisse, Patrick

**23. Signature and Date of Verbal SOC Where Applicable:**
Electronically Signed by Messick, Charles RN on 10/10/2025

**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 : 09/26/2025

**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 Careplans

SN WK1: 1 (10/10/25-10/11/25) ,WK2: 1 (10/12/25-10/18/25)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, limited endurance, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Anterior Left Thigh -

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

## SN Goals

PATIENT-STATED GOAL: "To walk without hip pain again"

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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

## PT Careplans

PT WK1: 1 (10/10/25-10/11/25) ,WK2: 3 (10/12/25-10/18/25) ,WK3: 2 (10/19/25-10/25/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, 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, GG0170I1 - Walk 10 Feet, 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,

## PT Goals

PATIENT-STATED GOAL: To walk by myself and go back to driving

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

Signature of Physician:

Date



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

Date
10/10/2025

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GG0130G1 - Lower Body Dressing, GG0130B1 - Oral Hygiene, #2 - Observable Surgical Wound - Anterior Left Thigh -

PROCEDURES: Home exercise program : Supine quad sets, glut sets, hip flexion, bridging. Standing knee flexion, hip abduction, plantarflexion, squats. . Sitting knee extension, ankle pumps, Bed mobility training , Hip precautions training, physician-ordered wound care, wound vacuum, 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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

1 - Step (curb) - 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

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

Toileting Hygiene - 06. Independent

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

12 Steps - 05. Setup or clean-up assistance

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

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

Car Transfer - 06. Independent

Don/Doff Footwear - 06. Independent

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