Home Health Certification and Plan of Care

Order ID: 1150/15857

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
761084938	01/27/2026	From: 01/27/2026 To: 03/27/2026	21110	217058

6. Patient's Name and Address
Patricia Thornton
331 Chimney Oak Dr,
JOPPA, MD 21084-
410-679-1799

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 06/07/1945 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	01/27/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	01/27/26
C82.13	Follicular lymphoma grade II intra-abdominal lymph nodes	01/27/26
I10.	Essential (primary) hypertension	01/27/26
I70.0	Atherosclerosis of aorta	01/27/26
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	01/27/26
M10.9	Gout unspecified	01/27/26
M51.379	Other intervertebral disc degeneration lumbosacral region	01/27/26
E78.5	Hyperlipidemia unspecified	01/27/26
K21.9	Gastro-esophageal reflux disease without esophagitis	01/27/26
E66.3	Overweight	01/27/26
Z68.31	Body mass index [BMI] 31.0-31.9 adult	01/27/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	01/27/26
Z90.710	Acquired absence of both cervix and uterus	01/27/26
Z85.3	Personal history of malignant neoplasm of breast	01/27/26
Z87.891	Personal history of nicotine dependence	01/27/26
Z91.81	History of falling	01/27/26

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

Cozaar - Losartan Potassium 100 mg 1 Tablet by mouth once a day
hydroCHLOROthiazide (ESIDRIX/HYDRODIURIL) 25 mg / 1 Tablet by mouth in the morning Take half
tablet by
mouth
every
morning
Glucophage - Metformin Hydrochloride 1,000 mg / 1 Tablet by mouth twice a day with food
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 125 mcg (5,000 unit) / 1 Tablet by mouth once a day
Aspirin 81Mg - Aspirin 81 mg= 1 tab by mouth twice a day Take 1 tab 81mg twice daily foe cardiac prevention measures
Aspirin 81Mg - Aspirin 81 mg= 1 tab by mouth twice a day Take 1 tab 81mg twice daily foe cardiac prevention measures
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg=1tab by mouth every 4 hours Take 1-2 tabsevery 4 hours as needed for pain 5/10 or greater
Extra Strength Tylenol - Acetaminophen 500mg=1tab by mouth every 6 hours Take 1 tab 500mg every 6 hours as needed for pain.
Colace - Docusate Sodium 100mg=1tab by mouth twice a day Take 1 tab 1oomg twice daily for constipation

14. DME and Supplies:
bath bench, rolling walker

15. Safety Measures:
walker precautions, smoke detectors , , bathroom safety, ambulates with device, ambulates with assistance, hip precautions, , restricted ROM, transfer with assist, , , diabetic precautions, , activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation,

18.B. Activities Permitted
Walker, Exercises Prescribed, , 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: 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
another facility/provider will be responsible for managing treatment
family/caregiver will be responsible for managing treatment

Homebound status: After undergoing Left 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.

Clinical Condition Requiring Homecare:

The patient is an 80-year-old female status post left total hip replacement performed on Friday, 01/23. She resides in a single-family home in Joppatown with her husband, who has dementia, and her daughter, who serves as her primary caregiver. The household also includes two small dogs. During the initial postoperative period, the patient is staying on the main first-floor living area, which includes access to a half bathroom. She ambulates with a rolling walker and requires one-person assistance for safety. The patient reports that her pain is adequately controlled with her current pain management regimen and states that she had a bowel movement today. Past medical history is significant for abnormal findings on Pap smear, diabetic polyneuropathy, type 2 diabetes mellitus without complications, gastroesophageal reflux disease, hypertension, cataracts, history of radiation therapy, right breast cancer, and hyperlipidemia. The patient has no known drug allergies and is designated as full code. All prescribed medications are present in the home, and medication education was completed. The surgical bandage is intact, and photographs of the incision were uploaded to the patient's chart. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient presented with moderate postoperative pain and edema. Therapeutic exercises were initiated while the patient was positioned in her recliner and included heel slides, straight leg raises, and assisted lower extremity abduction and adduction. In sitting, the patient performed long arc quadriceps exercises, and in standing, she completed marching and heel raises. The patient ambulated up to approximately 400 feet using a rolling walker, demonstrating a heel-to-toe gait pattern with good tolerance. Education was provided regarding the appropriate use of ice for pain and edema management, and the patient demonstrated understanding of the instructions.
 Date of Order 01/27/2026 Orders Physician Face-to-Face Date: 01/13/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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 Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/27/2026

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 : 01/13/2026

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: 2 (01/27/26-01/31/26)

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: 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; 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, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, swelling of affected area, limited range of motion, limited endurance, limited strength, muscle weakness, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Other - Left hip -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Left hip -: 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, incentive spirometer, wound vacuum, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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 medicatio, * 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 relaxatio, * 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, caregiver administers and/or packages medications appropriately

PATIENT-STATED GOAL: Patient states she wants to heal from her hip surgery so she can bring her husband who is staying at a medical daycare home.

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 medicatio

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 relaxatio

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

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 2 (01/27/26-01/31/26) ,WK2: 2 (02/01/26-02/07/26) ,WK3: 2 (02/08/26-02/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea

PROCEDURES: cough/deep breathing exercises, incentive spirometer, therapeutic exercises, gait training/stair 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 medicatio, * how to maintain a diary to

PT Goals

PATIENT-STATED GOAL: The patient wants to walk straight

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 medicatio

patient/caregiver recalls

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/27/2026

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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 relaxatio	* 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 relaxatio

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