Home Health Certification and Plan of Care

Order ID: 1150/16590

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
341066417	02/26/2026	From: 02/26/2026 To: 04/26/2026	20450	217058

6. Patient's Name and Address

Dennis Shelford
8912 Tarpleys Cir,
ROSEDALE, MD 21237-
410-776-5240

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 07/16/1957 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	02/26/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	02/26/26
M16.12	Unilateral primary osteoarthritis left hip	02/26/26
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	02/26/26
E78.5	Hyperlipidemia unspecified	02/26/26
H40.10X0	Unspecified open-angle glaucoma stage unspecified	02/26/26
E55.9	Vitamin D deficiency unspecified	02/26/26
N52.8	Other male erectile dysfunction	02/26/26
R73.03	Prediabetes	02/26/26
K59.00	Constipation unspecified	02/26/26
Z85.46	Personal history of malignant neoplasm of prostate	02/26/26
Z87.891	Personal history of nicotine dependence	02/26/26
Z86.16	Personal history of COVID-19	02/26/26

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

Colace - Docusate Sodium 100 mg, Take 1 capsule by mouth twice a day Take 1 capsule by mouth 2 times a day . Discontinue once bowel movements are soft and regular
Cosopt - Dorzolamide Hydrochloride: Timolol Maleate eq 2 perc base;eq 0.5 perc base 22.3-6.8 mg/mL, Instill 1 drop both eyes twice a day Instill 1 drop in both eyes 2 times a day
Viagra - Sildenafil Citrate eq 50 mg base 100 mg, Take 1 tablet by mouth as necessary Take 1 tablet by mouth as needed 1 hour prior to sexual activity. Do not exceed 1 tablet in 24 hours
Xalatan - Latanoprost 0.005 %, Instill 1 drop both eyes at bedtime Instill 1 drop in both eyes daily at bedtime
Neurontin - Gabapentin 100 mg , Take 1 capsule by mouth three times a day Take 1 capsule by mouth 3 times a day
Relafen - Nabumetone 750 mg 500 mg, Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day with food
Voltaren Gel - Rolaids 1 % Top Gel, Apply to affected area(s) topical four times a day Apply to affected area(s) 4 times a day (Patient not taking: Reported on 11/21/2025)
Asa 81 Mg - Aspirin 81mg by mouth twice a day Take 1 tab twice daily for Cardiac
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth every 6 hours Take 1-2 tabs every 6 hours as needed for pain

14. DME and Supplies:

rolling walker, hand held shower, bath bench, , grab bars, walker, cane, 4 wheeled walker

15. Safety Measures:

walker precautions, , , , ambulates with device, , supervision at all times, aspiration precautions, ambulates with assistance, hip precautions, hand rails, bathroom safety, , activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Exercises Prescribed, Walker, 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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/26/2026

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 : 02/19/2026

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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20. Prognosis: good

22. A Rehabilitation Potential:	22.B.Discharge Plans
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.	another facility/provider will be responsible for managing treatment family/caregiver will be responsible for managing treatment

Homebound status: After undergoing Right Total Hip Arthroplasty, 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 68-year-old male who is status post right total hip arthroplasty performed for advanced osteoarthritis of the right hip. The patient reports a history of bilateral hip pain for more than 10 years, with the right hip significantly more symptomatic than the left. Prior to surgery, pain severity was reported as 8-9/10 and localized primarily to the buttocks and posterior hip, with occasional radiation to the groin. The pain was exacerbated by functional activities including bending, donning socks and shoes, and getting in and out of a car. Due to progressive pain and decreased mobility, the patient began using a cane for ambulation. The patient previously underwent intra-articular hip injections several years ago, which did not provide significant or lasting relief. Currently, the patient presents in the postoperative period following right total hip replacement with moderate postoperative pain and edema. Pain is being managed with acetaminophen (Tylenol) and oxycodone with adequate control. The patient resides in a single-family home with family members and currently ambulates using a walker with one-person assistance for safety. The patient is designated as full code, and all prescribed medications are available in the home. During this visit, the patient participated in therapeutic exercise and mobility training. The patient was positioned in supine and performed therapeutic exercises including heel slides and lower extremity abduction and adduction to promote joint mobility and muscle activation. In a seated position, the patient completed long arc quadriceps exercises to improve lower extremity strength. In standing, the patient performed marching exercises to facilitate weight shifting and functional mobility. Gait training was conducted with a walker, with emphasis placed on proper use of the assistive device and reinforcement of a heel-to-toe gait pattern to promote safe and efficient ambulation. Additionally, the patient received education on the appropriate application of ice to the surgical area to assist with management of postoperative pain and edema. The patient tolerated the session with participation and demonstrated understanding of the education provided. The plan of care includes continued therapeutic exercise, gait training, mobility progression, and ongoing education to improve strength, functional mobility, and overall postoperative recovery.
 Date of Order 02/26/2026 Orders Physician Face-to-Face Date: 02/19/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Hip Arthroplasty 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 WK1: 1 (02/26/26-02/28/26) ,WK2: 1 (03/01/26-03/07/26)

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, 8. Currently reports exhaustion

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:No Advance Directive

SN Goals

PATIENT-STATED GOAL: Patient states he wants to be able to walk up and down the stairs 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
* 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

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 2 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/26/2026

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PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, limited endurance, swelling of affected area, limited strength, muscle weakness, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Other - Right Hip - Pic on file with PT. Right total hip replacement surgical wound.

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Right Hip - Pic on file with PT. Right total hip replacement surgical wound.: 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, teach/coordinate/arrange medication packaging and/or administration

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, * 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, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (02/26/26-02/28/26) ,WK2: 3 (03/01/26-03/07/26) ,WK3: 2 (03/08/26-03/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Effect on Sleep, GG0170P1 - Picking Up Object, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, GG0170F1 - Toilet Transfer, 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

PROCEDURES: 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, * 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, 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To walk straight with out device

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

Shower/Bathe Self - 05. Setup or clean-up assistance

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

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

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

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
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Walk 150 Feet - 05. Setup or clean-up assistance

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	PAGE 4 of 4
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