Home Health Certification and Plan of Care

Order ID: 1150/17331

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
33121711	03/20/2026	From: 03/20/2026 To: 05/18/2026	23158	217058

6. Patient's Name and Address
Tangaba Crosby
1114 N. Patterson Park Avenue,
BALTIMORE, MD 21213-
443-801-6023

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 11/28/1972 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	03/20/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	03/20/26
M17.0	Bilateral primary osteoarthritis of knee	03/20/26
N18.31	Chronic kidney disease stage 3a	03/20/26
D63.1	Anemia in chronic kidney disease	03/20/26
E55.9	Vitamin D deficiency unspecified	03/20/26
H04.123	Dry eye syndrome of bilateral lacrimal glands	03/20/26
E78.00	Pure hypercholesterolemia unspecified	03/20/26
K21.9	Gastro-esophageal reflux disease without esophagitis	03/20/26
K59.09	Other constipation	03/20/26
R73.03	Prediabetes	03/20/26
E66.9	Obesity unspecified	03/20/26
Z68.37	Body mass index [BMI] 37.0-37.9 adult	03/20/26
Z87.891	Personal history of nicotine dependence	03/20/26
Z79.82	Long term (current) use of aspirin	03/20/26
Z79.891	Long term (current) use of opiate analgesic	03/20/26

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

Maxzide-25 - Hydrochlorothiazide: Triamterene 25 mg;37.5 mg / 1 Tablet by mouth once a day
ADIPEX-P 37.5 mg / 1 Capsule by mouth once a day before breakfast or 1 to 2 hours after breakfast (combination treatment with topiramate)
FLUOCINONIDE 0.05 perc 60 g topical twice a day Apply to affected area(s) Up to 4 times daily for 2 weeks. Ok to use 2 weeks on, 2 weeks off
Elavil - Amitriptyline Hydrochloride 25 mg / 1 Tablet by mouth once a day Take 2 tablets at bedtime
Prograf - Tacrolimus eq 1 mg base - by mouth three times a day Please dissolve 1mg tablet in 500mL of distilled sterile water. 10 mLs swish and spit 3 to 4 times daily.
Kenalog - Triamcinolone Acetonide 0.1 perc / Apply to affected areas topical twice a day for up to 2 weeks, then as needed. Do not apply to face or groin
Lactulose - Lactulose 10gm/15ml / Take 30 mL by mouth once a day in water or juice
Topamax - Topiramate 25 mg / 1 Tablet by mouth twice a day
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth every 6 hours 1-2 tabs every 6 hours as needed for pain
Colace - Docusate Sodium 100mg by mouth twice a day 1 tab twice daily for constipation
Extra Strength Tylenol - Acetaminophen 1000mg= 1 tab by mouth every 6 hours two tabs every 6 hours as needed for pain
Asa 81 Mg - Aspirin 81mg by mouth twice a day 1 tab twice daily for cardiac

14. DME and Supplies:
rolling walker, hand held shower, bath bench, grab bars, walker, cane, 4 wheeled walker

15. Safety Measures:
walker precautions, smoke detectors , , , , ambulates with device, ambulates with assistance, emergency phone # clearly displayed, hip precautions, supervision at all times, transfer with assist, , hand rails, bathroom safety, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
pcn sulfa antibiotics

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

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 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.

Clinical Condition Requiring Homecare:

The patient is a 53-year-old female evaluated at home for preoperative <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> prior to a planned right total hip replacement, with a reported 20-month history of progressively worsening right hip pain, significantly exacerbated over the past six weeks. She describes the pain as severe, constant, and stabbing in nature, localized to the groin and mid-right thigh, with a self-reported intensity of 20/10. Symptoms are aggravated by movement, prolonged sitting, and standing, and are most pronounced at night, frequently disrupting sleep. The patient also reports marked stiffness requiring assistance with bed mobility, as well as intermittent popping sensations in the hip and other joints. These symptoms have significantly impaired her mobility, activities of daily living, and ability to travel. She denies prior interventional management such as injections or prescription analgesics and is unable to take NSAIDs due to renal concerns. Current pain management includes daily acetaminophen (Tylenol Arthritis) and an unspecified nighttime medication for stiffness; she is not on opioid therapy. The patient resides in a multi-level row home in Baltimore City with her spouse, with multiple steps leading to the second-floor bedroom. She is a full code, with medications available in the home, and reports allergies to penicillin and sulfa antibiotics. She ambulates with a walker and requires one-person assistance. Following right total hip replacement (s/p right THR), the patient presents with moderate postoperative pain and edema. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the surgical dressing is intact with no signs or symptoms of infection, though mild swelling and bruising are noted at the surgical site. Pain is reported as controlled at this time. During the visit, the patient was alone and positioned supine for therapeutic exercises, including heel slides and assisted hip abduction/adduction. In a seated position, she performed long arc quadriceps exercises, marching, side kicks, and heel raises, completing 2 sets of 10 repetitions each. The patient ambulated approximately 200 feet and successfully negotiated stairs from the first to the second floor using a cane. The plan includes initiation of home-based physical therapy services to address strength, mobility, and functional independence, with progression to outpatient therapy when appropriate. Education was provided regarding safe mobility, exercise performance, and postoperative precautions.
 Date of Order 03/20/2026 Orders Physician Face-to-Face Date: 03/03/2026 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 Goals**

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/20/2026

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 : 03/03/2026

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: 1 (03/20/26-03/21/26) ,WK2: 1 (03/22/26-03/28/26)

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:POLST (Physician Orders for Life-Sustaining Treatment)

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 strength, muscle weakness, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, bruising/discoloration, swell/redness surround. skin, #1 - Observable Surgical Wound - Other - Right Hip - Right surgical hip incision

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - Right Hip - Right surgical hip incision: 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

PATIENT-STATED GOAL: Patient states she wants to walk with out 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 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
* 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
* 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

PT Careplans	PT Goals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/20/2026

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PT WK1: 1 (03/20/26-03/21/26) ,WK2: 3 (03/22/26-03/28/26) ,WK3: 2 (03/29/26-04/04/26)

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: Home exercise program : Supine quad sets, glut sets, hip flexion, bridging. Standing knee flexion, hip abduction, plantarflexion, squats. Sitting knee extension, ankle pumps , 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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

PATIENT-STATED GOAL: The patient wants to walk pain free

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

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

Car Transfer - 06. Independent

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

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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 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

Sit to Stand - 06. Independent

12 Steps - 05. Setup or clean-up assistance

Upper Body Dressing - 06. Independent

Signature of Physician:

Date

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

Date
03/20/2026