

Home Health Certification and Plan of Care				Order ID: 1150/17956	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
63159861		04/15/2026		From: 04/15/2026 To: 06/13/2026	
4. Medical Record No.		5. Provider No.			
24009		217058			
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Jeri Wilson 221 Garnett Rd, JOPPA, MD 21085- 443-922-7868			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB 01/02/1945 9.Sex Female			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
11. ICD Principal Diagnosis Date			Zestril - Lisinopril 40 mg / 1 Tablet by mouth daily		
Z47.1 Aftercare following joint replacement surgery 04/15/26			OXYCODONE 5 mg by mouth every 4 hours as needed for pain Take 1 to 2 tablets		
13. ICD Other Pertinent Diagnoses Date			NORVASC 5 mg / 1 Tablet by mouth daily HTN		
Z96.642 Presence of left artificial hip joint 04/15/26			NEURONTIN 300 mg / 1 Capsule by mouth during day and two capsules at night		
M16.11 Unilateral primary osteoarthritis right hip 04/15/26			LISINOPRIL 40 mg Oral daily		
M17.0 Bilateral primary osteoarthritis of knee 04/15/26			HYDROCHLOROTHIAZIDE 25 mg Oral every morning		
I10. Essential (primary) hypertension 04/15/26			ASPIRIN 81 mg Oral 2 TIMES A DAY		
E78.00 Pure hypercholesterolemia unspecified 04/15/26			ACETAMINOPHEN 500 mg Oral EVERY 6 HOURS AS NEEDED		
M47.816 Spondylosis w/o myelopathy or radiculopathy lumbar region 04/15/26			DOCUSATE 100 mg Oral 2 TIMES A DAY Stool softener		
J30.9 Allergic rhinitis unspecified 04/15/26			CRESTOR 5 mg / 1 Tablet by mouth daily to prevent heart attack and stroke		
Z85.828 Personal history of other malignant neoplasm of skin 04/15/26			Miralax - Polyethylene Glycol 3350 17gm/scoopful 1 scope by mouth once a day Due to constipation		
Z79.82 Long term (current) use of aspirin 04/15/26					
Z87.891 Personal history of nicotine dependence 04/15/26					
14. DME and Supplies: bath bench, walker, cane			15. Safety Measures: standard precautions, fall precautions, ambulates with device, walker precautions, medication safety, no lifting, hip precautions, bathroom safety, anticoagulant precautions		
16. Nutrition: regular			17. Allergies: lipitor latex penicillin pravastin relafin sulfa antibiotics		
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: No					
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: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.			22.B.Discharge Plans SN: family/caregiver will be responsible for managing treatment PT: patient will		
Homebound status: After undergoing Left Total Hip Replacement surgery, 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: <p class="MsoNoSpacing">The patient is an 81-year-old female admitted to home health services following an elective left total hip replacement, returning home the same day with assistance from family. Her past medical history is significant for hypertension, osteoarthritis, chronic back pain, spondylosis, hypercholesterolemia, and a history of smoking. She reports pain at a level of 5/10, which is managed with medication and ice. On assessment, vital signs are within normal limits. The patient presents with decreased range of motion and strength, impaired balance, ambulatory dysfunction, and deficits in bed mobility and transfers, requiring assistance for all mobility and placing her at high risk for falls, making leaving the home a taxing effort. She ambulates with a walker, and her husband is actively involved in her care. Interventions included assistance with compression stockings, education on edema management, proper lower extremity positioning, and recognition of signs and symptoms of infection. A home exercise program was initiated, including ankle pumps, quadriceps sets, and gluteal sets, and the patient was instructed on anterior hip precautions. Skilled physical therapy is indicated to improve function, reduce fall risk, and prevent further decline.</p><p class="MsoNoSpacing"></p><p class="MsoNoSpacing">Date of Order</p><p class="MsoNoSpacing">04/15/2026 Physician Face-to-Face Date: 03/30/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left Total Hip Replacement surgery Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</p><p class="MsoNoSpacing"> 1 - SOC - SN Notes: PT Eval Notes: </p><p class="MsoNoSpacing">Physician: Narcisse, Patrick</p>					
SN Careplans			SN Goals		
SN WK1: 1 (04/15/26-04/18/26) ,WK2: 1 (04/19/26-04/25/26)			PATIENT-STATED GOAL: To walk better without pain.		
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			GOALS		
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance			patient/caregiver recalls		
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion			* how to achieve wound healing including cleaning and dressing wound		
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			* position changes		
			* skin care		
			* diet modification		
			* record wound measurements		
			* recalls related medication(s) purpose, schedule		
			patient/caregiver recalls		
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 04/15/2026				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 : 03/30/2026		
27. Attending Physician's Signature and Date Signed 04/22/2026 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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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: M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, nausea/vomiting, limited strength, Pain Interference with ADLs, balance deficit, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Left Hip - Left hip replacement surgery PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Hip - Left hip replacement surgery: Remove dressing on the surgical site and Iota. otherwise cover with a dry gauze if drainage occurs., cough/deep breathing exercises, incentive spirometer 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	* 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
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PT Careplans PT WK1: 2 (04/15/26-04/18/26) ,WK2: 3 (04/19/26-04/25/26) ,WK3: 1 (04/26/26-05/02/26) PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, 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: Medication management : Review medication with pt, cough/deep breathing exercises, home exercise program: Laq, heelraises, aps, glut sets, standing hip flexion on LLE, hamstring curls, equipment training, work simplification/energy conservation, 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	PT Goals PATIENT-STATED GOAL: To improve my walking and eventually get off the Walker. GOALS Chair to Bed to Chair - 06. Independent Toilet Transfer - 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 Sit to Stand - 06. Independent Car Transfer - 06. Independent
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/15/2026

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Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent			Walk 10 Feet - 04. Supervision or touching assistance Walk 50 ft with 2 Turns - 04. Supervision or touching assistance Walk 150 Feet - 04. Supervision or touching assistance 1 - Step (curb) - 04. Supervision or touching assistance 4 Steps - 04. Supervision or touching assistance Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Shower/Bathe Self - 03. Partial/moderate assistance Upper Body Dressing - 06. Independent	

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