

Home Health Certification and Plan of Care				Order ID: 1150/18025	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
95169887		04/17/2026		From: 04/17/2026 To: 06/15/2026	
				4. Medical Record No.	
				24297	
				5. Provider No.	
				217058	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Teresa Smith 847 Bosley Ave, TOWSON, MD 21204- 443-717-4891				HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239	
8. DOB 03/17/1963 9.Sex Female				10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
11. ICD Z47.1		Principal Diagnosis Aftercare following joint replacement surgery		Date 04/17/26	
13. ICD Z96.642 E78.2 E03.9 Z86.16		Other Pertinent Diagnoses Presence of left artificial hip joint Mixed hyperlipidemia Hypothyroidism unspecified Personal history of COVID-19		Date 04/17/26 04/17/26 04/17/26 04/17/26	
14. DME and Supplies: walker, cane				15. Safety Measures: walker precautions, medication safety, hip precautions, fall precautions, bathroom safety, ambulates with device	
16. Nutrition: Z. NO PHYSICIAN-ORDERED DIET				17. Allergies: atorvastatin bactrim sulfamethoxazole	
18.A. Functional Limitations Ambulation				18.B. Activities Permitted 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: 1. Rarely, 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 SN: patient will be responsible for managing treatment PT: another facility/provi	
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">A 63-year-old female with a history of hip arthritis is recovering from a left total hip replacement and has been admitted to home health services. She is alert and oriented 4, reports minimal to moderate pain with movement, and is not in distress. The patient ambulates within the home using a rolling walker and is able to negotiate stairs with the use of a railing. Physical assessment revealed lungs clear to auscultation, audible bowel sounds, palpable pulses in all extremities, and trace edema at the surgical site; knee-length compression is in place. Vital signs are stable (T 97.9F, pulse 82 bpm, SpO 98% on room air, BP 122/60 seated), and her last bowel movement was reported on Wednesday. The surgical dressing was assessed and documented. The patient was not using her incentive spirometer and was educated on its importance and proper use, as well as on ice application for edema management. During the visit, she participated in therapeutic exercises including heel slides, long arc quadriceps, marching, and heel raises (10 repetitions 2 sets each), and ambulated approximately 300 feet with a rolling walker. She has family support available to assist with her care during recovery.</o:p></p> <p class="MsoNoSpacing"><o:p> </o:p></p> <p class="MsoNoSpacing">Date of Order<o:p></o:p></p> <p class="MsoNoSpacing">04/17/2026 Physician Face-to-Face Date: 04/03/2026 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<o:p></o:p></p> <p class="MsoNoSpacing"> 1 - SOC - SN Notes: PT Eval Notes: <o:p></o:p></p> <p class="MsoNoSpacing">Physician: Narcisse, Patrick</p>					
SN Careplans				SN Goals	
SN WK1: 1 (04/17/26-04/18/26) ,WK2: 1 (04/19/26-04/25/26)				PATIENT-STATED GOAL: I want my hip to heal.	
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 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	
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance				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	
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications				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	
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.				patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule	
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 04/17/2026				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 : 04/03/2026	
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. PAGE 1 of 3	

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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 PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1400 - Dyspnea, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, swell/redness surround. skin, red/tender pressure points, #1 - Non-Observable Surgical Wound - Anterior Left Hip - PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Hip -, cough/deep breathing exercises, incentive spirometer, physician-ordered wound care 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				
PT Careplans PT WK1: 1 (04/17/26-04/18/26) ,WK2: 3 (04/19/26-04/25/26) ,WK3: 2 (04/26/26-05/02/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, GG017001 - 12 Steps, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, GG0170P1 - Picking Up Object, GG0170F1 - Toilet Transfer, 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: Heel slides, long arc , marching , SLR, marching and heel raises, therapeutic exercises: Heel slides, long arc , marching , SLR, marching and heel raises, 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, 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 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 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 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 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 4 Steps - 05. Setup or clean-up assistance		
Signature of Physician:		Date PAGE 2 of 3		
Optional Name/Signature of Nurse/Therapist: Electronically Signed by Messick, Charles RN		Date 04/17/2026		

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

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