Home Health Certification and Plan of Care

Order ID: 1150/18316

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
051003497	04/24/2026	From: 04/24/2026 To: 06/22/2026	25086	217058

6. Patient's Name and Address
Robin Brabham
1721 Jacobs Meadow Dr,
Severn, MD 21144-
202-361-6089

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 05/18/1969 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	04/24/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	04/24/26
M16.12	Unilateral primary osteoarthritis left hip	04/24/26
I10.	Essential (primary) hypertension	04/24/26
E78.5	Hyperlipidemia unspecified	04/24/26
J31.0	Chronic rhinitis	04/24/26
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	04/24/26
F41.9	Anxiety disorder unspecified	04/24/26
R73.03	Prediabetes	04/24/26
Z87.891	Personal history of nicotine dependence	04/24/26

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

HYZAAR 50-12.5 mg / 1 Tablet by mouth daily
LIPITOR 40 mg / 1 Tablet by mouth daily For cholesterol and heart protection
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 mg by mouth every 4 hours 1 tab every 4 hours as needed for moderate to severe pain
Docusate Sodium - Docusate Sodium 100 mg by mouth twice a day
Asa 81 Mg - Aspirin 81 mg by mouth twice a day
Ibuprofen - Ibuprofen 600 mg 1 tab by mouth every 6 hours 1 tab every 6 hours as needed for mild to moserate pain

14. DME and Supplies:
rolling walker, commode

15. Safety Measures:
standard precautions, hip precautions, fall precautions, ambulates with device

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: NA Patient nonresponsive, 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
patient 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 56-year-old female with a past medical history significant for bilateral hip osteoarthritis, status post right total hip replacement performed on 04/23/2026, currently receiving skilled nursing and physical therapy services for postoperative care, follow-up, and monitoring. Upon assessment, the patient was alert and oriented to person, place, and time, and was observed resting comfortably in a recliner with her son present during the visit. She denied chest pain or discomfort and reported a pain level of 5/10 localized to the surgical site, which she stated is adequately managed with prescribed analgesics. An ice pack was in place over the right hip. The surgical incision was covered with a non-removable dressing that was clean, dry, and intact, with planned removal on 04/29/2026. The patient reported absence of bowel movement since surgery accompanied by mild abdominal cramping, which she attributed to gas; she is currently on a bowel regimen, and education was provided regarding the use of stool softeners (Colace). Mild bilateral lower extremity edema was noted, and the patient was compliant with prescribed TED stockings. Medication reconciliation was completed with no discrepancies or need for refills identified. Admission paperwork was reviewed and signed, and the patient verbalized agreement with the plan of care. She is scheduled for surgical follow-up on 05/07/2026 and to begin outpatient physical therapy on 05/11/2026. Following surgery, the patient demonstrates decreased endurance, reduced lower extremity strength, impaired balance, and limited functional mobility, contributing to an increased risk for falls. She requires assistance from another person and the use of an assistive device for safe mobility outside the home. Physical therapy evaluation was completed with consents obtained. The patient presents with right hip pain, decreased hip strength, difficulty with transfers and stair negotiation, unsteady gait, and impaired balance. Skilled home physical therapy services are indicated to address these deficits, improve strength and mobility, enhance safety with ambulation and transfers, and promote independence while reducing fall risk and preventing further functional decline. Education and interventions provided included instruction on anterior hip precautions, edema management strategies (including lower extremity elevation above heart level during rest and use of compression garments as prescribed), and recognition of signs and symptoms of infection such as fever, chills, redness, swelling, drainage, or uncontrolled pain. The patient was also educated on fall prevention strategies and home safety modifications per the patient handbook. Transfer training was performed using a walker with emphasis on proper hand and foot placement, forward weight shifting, and controlled descent to seated surfaces; the patient required minimal assistance to standby assistance for safety. Therapeutic exercises were initiated in the supine position, including ankle pumps, quadriceps sets, and gluteal sets (1 set of 20 repetitions), with a home exercise program provided and instructions to perform exercises twice daily. Passive range of motion of the right hip was performed. Gait training on level surfaces with a walker was conducted with standby assistance, including cues for proper positioning, step height, and step length; the patient was advised to use the walker at all times. The patient was further educated on the importance of regular ambulation to promote circulation and prevent complications, with recommendations to initiate short walks every 1-2 hours within the home and gradually progress duration starting at 3-5 minutes as tolerated. Instructions were given for cryotherapy application to the right hip for 20 minutes with appropriate skin protection and monitoring every 5 minutes. Pain management education included taking medications at the onset of pain, awareness of potential side effects such as dizziness and constipation, and guidance to seek immediate medical attention for chest pain, shortness of breath, or unrelieved pain. The patient was also advised to take pain medication approximately one hour prior to therapy sessions. The physical therapy plan of care was discussed and established with the patient, who verbalized understanding and agreement. The patient is scheduled for home physical therapy services with the following frequency: 1 visit in the first week, 3 visits per week (Monday, Tuesday, Thursday) for one week, followed by 2 visits per week (Tuesday and Thursday) for one week, with transition to outpatient physical therapy on 05/11/2026. Continued skilled nursing and therapy services are warranted to monitor postoperative recovery, manage symptoms, and support progression toward prior level of function and independence.
 Date of Order 04/24/2026 Orders Physician Face-to-Face Date: 04/15/2026 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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 04/24/2026

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 : 04/15/2026

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 Careplans

SN WK1: 1 (04/24/26-04/25/26) ,WK2: 1 (04/26/26-05/02/26)

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: 10. None of the above

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

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M2020 - Oral Med Management, meal preparation, M2102c - Med Admin, M1400 - Dyspnea, swelling of affected area, limited range of motion, balance deficit, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals

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 keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately

SN Goals

PATIENT-STATED GOAL: To get back to my normal self

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 medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

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

meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (04/24/26-04/25/26) ,WK2: 3 (04/26/26-05/02/26) ,WK3: 2 (05/03/26-05/09/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PT Goals

PATIENT-STATED GOAL: To get back to walking with some type of normalcy

GOALS
Toilet Transfer - 06. Independent

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/24/2026

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PROCEDURES: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, hip abd Seated-LAQ hip flex, pillow squeeze Standing-Mini squat, heel/toe raise, hip flex, leg curls., therapeutic modalities: Apply ice to R hip x 20 minutes with necessary barrier and skin assessments q 5 minutes., 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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 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, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 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

Oral Hygiene - 06. Independent

Eating - 06. Independent

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Signature of Physician:	Date
	PAGE 3 of 3
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Electronically Signed by Messick, Charles RN	04/24/2026