

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	
051003497		04/24/2026		From: 04/24/2026 To: 06/22/2026	
				4. Medical Record No.	
				25086	
				5. Provider No.	
				217058	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Robin Brabham 1721 Jacobs Meadow Dr, Severn, MD 21144- 202-361-6089			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
05/18/1969			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	
14. DME and Supplies:			15. Safety Measures:		
rolling walker, commode			standard precautions, hip precautions, fall precautions, ambulates with device		
16. Nutrition:			17. Allergies:		
Z. NO PHYSICIAN-ORDERED DIET			no known allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
Ambulation			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:			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.			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:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 04/24/2026					
24. Physician's Name and Address			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.		
Patrick Narcisse 2391 Greenspring Dr Timonium , MD 21093 PHONE: 410-847-3000 FAX: NPI: 1508397092			F2F date : 04/15/2026		
27. Attending Physician's Signature and Date Signed			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.		
05/04/2026 Date of physician last face-to-face			PAGE 1 of 3		

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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
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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
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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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		

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