Home Health Certification and Plan of Care

Order ID: 1150/18404

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
27302887	05/01/2026	From: 05/01/2026 To: 06/29/2026	25312	217058

6. Patient's Name and Address
Steven Hasler
1232 Sparks Rd,
Sparks, MD 21151-
443-570-3208

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 11/29/1962 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	05/01/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	05/01/26
I10.	Essential (primary) hypertension	05/01/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/01/26
E78.5	Hyperlipidemia unspecified	05/01/26
G43.109	Migraine with aura not intractable w/o status migrainosus	05/01/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/01/26
J30.9	Allergic rhinitis unspecified	05/01/26
E66.9	Obesity unspecified	05/01/26
Z68.34	Body mass index [BMI] 34.0-34.9 adult	05/01/26
Z87.891	Personal history of nicotine dependence	05/01/26
Z86.11	Personal history of tuberculosis	05/01/26

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

INDERAL 10 mg/tablet / Take 1 to 2 tablets by mouth daily for migraine prevention
COZAAR 50 mg / 1 Tablet by mouth daily HTN
LIPITOR 20 mg / 1 Tablet by mouth daily for cholesterol and heart protection.
Wellbutrin Sr - Bupropion Hydrochloride 100 mg / 1 Tablet by mouth 2 times a day
TOPAMAX 50 mg / 1 Tablet by mouth 2 times a day Migraine
Esidrix - Hydrochlorothiazide 25 mg / 1 Tablet by mouth every morning HTN/Fluid
PEPCID 40 mg / 1 Tablet by mouth daily GERD
ROXICODONE 5 mg/tablet / Take 1 to 2 tablets by mouth every 4 hours as needed for pain (Patient not taking: Reported on 4/24/2026)
MOTRIN 600 mg / 1 Tablet by mouth every 6 hours as needed Take with food. (Patient not taking, Reported on 4/24/2026)
COLACE 100 mg / 1 Capsule by mouth twice a day (Patient not taking: Reported on 4/24/2026)
ECOTRIN 81 mg / 1 Tablet by mouth 2 times a day
ACETAMINOPHEN 500 mg / 1 Tablet by mouth every 6 hours as needed
ASTELIN 137 mcg (0.1 %) Nasl Spray / Use 1 spray Each nostril twice a day
Epipen - Epinephrine 0.3 mg/0.3 mL Inj AutoInjector / Inject 0.3 mL intramuscular as necessary (for allergic reaction) (Patient not taking, Reported on 4/24/2026)
tirzepatide, weight loss, (ZEPBOUND KWIKPEN) SubQ Pen Injector 12.5 mg/0.6 mL (50 mg/2.4 mL) / Inject 12.5 mg subcutaneous once a week Dx. E66.01 weight loss

14. DME and Supplies:
walker, bath bench

15. Safety Measures:
walker precautions, standard precautions, medication safety, hip precautions, fall precautions, bathroom safety, anticoagulant precautions, ambulates with device

16. Nutrition:
low sodium

17. Allergies:
shellfish!alli metformin naltrexone paxlovid phentermine

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: 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 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:
The patient is a 63-year-old male status post total hip replacement surgery with a past medical history significant for hypertension, obesity, allergic rhinitis, hyperlipidemia, gastroesophageal reflux disease (GERD), sleep apnea, and osteoarthritis of the right hip. Patient resides with his wife, who serves as his primary caregiver, in a single-family home with one step to enter. A first-floor setup is currently available for safety and accessibility, although the patient normally sleeps on the second floor, which requires navigating 14 steps without handrails. Patient is alert and oriented 4, cooperative, and able to participate appropriately during assessment and therapy sessions. Vital signs were within normal limits, and lung sounds were clear to auscultation bilaterally. Physical assessment was completed without acute concerns noted. The surgical incision site is covered with an Aquacel dressing, which is scheduled to be removed on postoperative day seven and then left open to air per surgeon's instructions. Patient is wearing compression stockings as ordered for DVT prophylaxis. Medication reconciliation and review were completed with the patient, and education was provided regarding medication compliance, pain management, constipation prevention related to decreased mobility and pain medication use, use of ice therapy for swelling and discomfort, and the importance of adherence to prescribed therapeutic exercises. Patient currently ambulates approximately 30 feet on indoor surfaces using a rolling walker with supervision and verbal cues for proper gait pattern and safety awareness. Transfers to bed, chair, and toilet are performed with supervision, while bed mobility requires minimal assistance, particularly with management of the operative lower extremity. Outside ambulation, stair negotiation, and car transfer assessment were deferred at this visit. Patient tolerated therapeutic exercises well, including supine quadriceps sets, gluteal sets, hip flexion exercises, bridging, seated knee extensions, and ankle pumps performed for 10 repetitions each. Due to decreased strength, impaired mobility, fall risk, and significant effort required to leave the home, as evidenced by a Tinetti balance and gait score of 14/28, the patient is considered homebound. Skilled home health therapy services are indicated to improve strength, mobility, gait safety, functional independence, and overall recovery following hip replacement surgery.
 Date of Order 05/01/2026 Orders Physician Face-to-Face Date: 04/29/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to 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
 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 05/01/2026

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 : 04/29/2026

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 (05/01/26-05/02/26) ,WK2: 1 (05/03/26-05/09/26)

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, balance deficit, Pain Interference with ADLs, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Hip - Right hip surgical site

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Hip - Right hip surgical site: Right hip: remove aquacel dressing on the 7th day post op and LOTA, otherwise cover with a dry gauze dressing 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

SN Goals

PATIENT-STATED GOAL: To walk around the house without an assistive device

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
* 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

PT Careplans

PT WK1: 1 (05/01/26-05/02/26) ,WK2: 3 (05/03/26-05/09/26) ,WK3: 2 (05/10/26-05/16/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, GG0170G1 - Car Transfer, 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, 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,

PT Goals

PATIENT-STATED GOAL: To walk independently without pain

GOALS
Toilet Transfer - 06. Independent

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

Picking Up Object - 04. Supervision or touching assistance

Signature of Physician:

Date

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

Date
05/01/2026

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GG0170D1 - Sit to Stand

PROCEDURES: Hip precautions : Avoid hip flexion greater than 90 degrees, home exercise program: Supine quad sets, glut sets, hip flexion, bridging. Standing knee flexion, hip abduction, plantarflexion, squats. Sitting knee extension, ankle pumps, equipment training, 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 - 02. Substantial/maximal assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 05. Setup or clean-up assistance, Upper Body Dressing - 06. Independent

Car Transfer - 05. Setup or clean-up assistance

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

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 05. Setup or clean-up assistance

Upper Body Dressing - 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

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

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

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

Oral Hygiene - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/01/2026