Home Health Certification and Plan of Care

Order ID: 1150/18562

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01183000	05/08/2026	From: 05/08/2026 To: 07/06/2026	11320	217058

6. Patient's Name and Address

Vicki Bradley
514 Old Westminster Pike Apt B,
WESTMINSTER, MD 21157-
410-259-1355

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 03/01/1968 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	05/08/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	05/08/26
E78.5	Hyperlipidemia unspecified	05/08/26
M48.061	Spinal stenosis lumbar region without neurogenic claud	05/08/26
G62.9	Polyneuropathy unspecified	05/08/26
E55.9	Vitamin D deficiency unspecified	05/08/26
G89.4	Chronic pain syndrome	05/08/26
Q07.00	Arnold-Chiari syndrome without spina bifida or hydrocephalus	05/08/26
G47.419	Narcolepsy without cataplexy	05/08/26
M47.812	Spondylosis w/o myelopathy or radiculopathy cervical region	05/08/26
F33.9	Major depressive disorder recurrent unspecified	05/08/26
F10.10	Alcohol abuse uncomplicated	05/08/26
E66.9	Obesity unspecified	05/08/26
Z68.32	Body mass index [BMI] 32.0-32.9 adult	05/08/26
Z96.643	Presence of artificial hip joint bilateral	05/08/26
Z87.891	Personal history of nicotine dependence	05/08/26

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

Protonix - Pantoprazole Sodium 40 mg , Take 1 tablet by mouth once a day daily 30 to 60 minutes before breakfast and dinner
Toprol Xl - Metoprolol Tartrate 50 mg , Take 1 tablet by mouth once a day
Flexeril - Cyclobenzaprine Hydrochloride 10 mg , Take 1 tablet by mouth three times a day 3 times a day as needed
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth every 4 hours PRN
Lotrimin Af - Clotrimazole 1 % Top Cream , Apply to affected area(s) topical twice a day
Kenalog - Triamcinolone Acetonide 0.1 % Top Cream , Apply to affected area(s) topical twice a day

14. DME and Supplies:

walker, rolling walker, hand held shower, grab bars, cane, bath bench

15. Safety Measures:

walker precautions, transfer with assist, supervision at all times, standard precautions, smoke detectors , medication safety, hand rails, , fall precautions, anticoagulant precautions, bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

sufa aspirin latex ibuprofen morphine naproxen pcn neurontin

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Cane, 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: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

patient will be responsible for managing treatment

Homebound status: After undergoing Total left 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:

Patient is a 58-year-old female with a past medical history significant for bilateral hip replacements, including a total right hip replacement performed in March 2025 and a recent total left hip replacement completed on May 7, 2026. Upon RN arrival, patient greeted nurse at the door and was observed ambulating without the use of a walker or cane despite postoperative recommendations. Patient was reminded and educated on the importance of using prescribed assistive devices to promote safety and reduce fall risk during recovery. Patient resides with her boyfriend, Brian, who is currently her primary and only caregiver and assists with daily care needs. Home environment assessment revealed the presence of three dogs, including two small dogs and one large dog, which were placed outside during the visit. Patient was instructed to remain cautious while ambulating around pets to prevent falls or injury. Additional fall hazards were identified within the home, including soiled dog pads on the floor, which were discussed with the patient as significant environmental safety concerns requiring prompt cleanup and maintenance to reduce risk of slipping or falling. It was also noted that the patient's boyfriend smokes inside the home, and education was provided regarding maintaining a clean and healthy postoperative recovery environment. Patient reported minimal pain at the time of visit and stated she was feeling well overall. Patient verbalized compliance with prescribed medications; however, vital signs were within normal limits except for elevated blood pressure, which patient attributed to not yet taking her prescribed antihypertensive medication prior to the visit. Patient was reminded of the importance of medication compliance and adherence to prescribed treatment regimens. Education was also reinforced regarding physician orders for showering, postoperative precautions, and proper surgical site care to prevent complications and promote healing. Patient denied any additional questions or concerns at the time of visit and appeared receptive to teaching and recommendations provided.
 Date of Order 05/08/2026 Orders Physician Face-to-Face Date: 04/30/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Total left 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
 Physician Narcisse, Patrick

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/08/2026

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 : 04/30/2026

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 WK1: 1 (05/08/26-05/09/26) ,WK2: 1 (05/10/26-05/16/26)

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 > 10

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, Home Safety, Home Safety, M2102f - Patient Supervision, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, abnormal blood pressure, M1400 - Dyspnea, nausea/vomiting, limited strength, limited range of motion, limited endurance, swelling of affected area, muscle weakness, poor muscle tone, balance deficit, Pain Interference with ADLs, Pain Effect on Sleep, obesity, red/tender pressure points, swell/redness surround. skin, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange for maintenance of clean/uncluttered living area, coordinate/arrange access to adequate trash/sewage disposal

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered, patient has access to adequate trash/sewage disposal, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PATIENT-STATED GOAL: To walk without a walker or cane

GOALS
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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's living environment is clean/uncluttered

patient has access to adequate trash/sewage disposal

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/08/2026