# Home Health Certification and Plan of Care

**Order ID: 1150/18844**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 92198683 | 05/20/2026 | From: 05/20/2026 To: 07/18/2026 | 25087 | 217058 |

**6. Patient's Name and Address**
Sharon Speelman-Pomplon
102 Dameson Rd,
EDGEWOOD, MD 21040-
443-600-9308

**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** 12/10/1964 | **9.Sex** Female

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| Z47.1 | Aftercare following joint replacement surgery | 05/20/26 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| Z96.641 | Presence of right artificial hip joint | 05/20/26 |
| J43.9 | Emphysema unspecified | 05/20/26 |
| I70.0 | Atherosclerosis of aorta | 05/20/26 |
| F41.9 | Anxiety disorder unspecified | 05/20/26 |
| M17.11 | Unilateral primary osteoarthritis right knee | 05/20/26 |
| K52.839 | Microscopic colitis unspecified | 05/20/26 |
| Z79.82 | Long term (current) use of aspirin | 05/20/26 |
| Z79.1 | Long term (current) use of non-steroidal non-inflam (NSAID) | 05/20/26 |
| Z87.891 | Personal history of nicotine dependence | 05/20/26 |

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

COLACE 100 mg / 1 Capsule by mouth 2 times a day
Spiriva Respimat - Tiotropium Bromide 2.5 mcg/actuation Inhl Mist / Inhale 2 Puffs by mouth daily
Entocort Ec - Budesonide 3 mg/capsule / Take 3 capsules by mouth every morning
WIXELA INHUB Inhl Disk w/devi 250-50 mcg/dose / Inhale 1 Puff by mouth as necessary every 4 hours. (rescue inhaler)
TYLENOL 500 mg / 1 Tablet by mouth as necessary
ECOTRIN 0 Delayed Release 81 mg / 1 Tablet by mouth 2 times a day
(Patient not taking: Reported on 4/17/2026)
TRAMADOL 50 mg Oral EVERY 6 HOURS AS NEEDED

**14. DME and Supplies:**
bath bench, walker, enema supplies

**15. Safety Measures:**
sharps precautions, walker precautions, ambulates with device, medication safety, bedrails up while in bed, ambulates with assistance, standard precautions, , bathroom safety

**16. Nutrition:**
regular

**17. Allergies:**
sulfa drugs

**18.A. Functional Limitations**
Endurance, Ambulation

**18.B. Activities Permitted**
Up As Tolerated, Walker

**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**
SN: patient will be responsible for managing treatment PT: family/caregiver will

**Homebound status:** After undergoing Right 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 61-year-old female referred to home health services following an elective right total hip replacement (R THR), returning home the same day with assistance from her spouse, who is her primary caregiver. Her past medical history is significant for emphysema, microscopic colitis, collagenous colitis, and abnormal pulmonary function tests. Physical assessment revealed the surgical incision covered with a non-removable Mepilex dressing, with plans for removal on postoperative day seven and to leave the incision open to air if no drainage is present; an image of the dressing was uploaded to the patient's chart. The patient denies shortness of breath, dizziness, or lightheadedness and reports pain at a level of 4/10, managed with prescribed medication and ice. She reports constipation since surgery despite taking docusate sodium and Miralax, likely exacerbated by narcotic pain medication and her history of collagenous colitis; she was encouraged to increase fluid intake, reduce narcotic use as tolerated, and use a saline enema if necessary. The patient ambulates with a walker and presents with decreased lower extremity strength and range of motion, impaired balance, gait dysfunction, bed mobility and transfer deficits, difficulty negotiating steps, and a high fall risk requiring assistance for all mobility. Education was provided regarding edema management, proper lower extremity positioning, signs and symptoms of infection, and safety precautions. A home exercise program was initiated, including ankle pumps, quad sets, gluteal sets, and long arc quads. Continued skilled physical therapy is recommended to improve mobility, strength, balance, safety, and independence and to prevent further functional decline.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 05/20/2026<br> Physician Face-to-Face Date: 04/17/2026<br> Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Hip Replacement surgery<br> 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> <br> 1 - SOC - SN Notes: <br> PT Eval Notes: <span style="font-size: 10.5pt; background-image: initial; background-position: initial; background-size: initial; background-repeat: initial; background-attachment: initial; background-origin: initial; background-clip: initial;"><o:p></o:p> Physician: Narcisse, Patrick

**SN Careplans**

SN WK1: 1 (05/20/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26)

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

**SN Goals**

PATIENT-STATED GOAL: To walk without pain.

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

**23. Signature and Date of Verbal SOC Where Applicable:**
Electronically Signed by Messick, Charles RN on 05/20/2026

**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 : 04/17/2026

**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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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, M1033 - Exhaustion, M1400 - Dyspnea, constipation, limited strength, balance deficit, Pain Interference with ADLs, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Hip - Right hip replacement surgery

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

* 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: 2 (05/20/26-05/23/26) ,WK2: 3 (05/24/26-05/30/26) ,WK3: 1 (05/31/26-06/06/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, 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

PROCEDURES: Medication management : Review medication with pt and caregiver, cough/deep breathing exercises, home exercise program: Aps, qs, GS, laq, standing hip flexion, hamstring curls, equipment training, work simplification/energy conservation, gait training/stair training, transfers training

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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand -

## PT Goals

PATIENT-STATED GOAL: To progress off walker get stronger amd walk independently again

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 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

Toilet Transfer - 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

| Signature of Physician: | Date |
|---|---|
| | PAGE 2 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 05/20/2026 |

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| | |
|---|---|
| 05. Setup or clean-up assistance, Toilet Transfer - 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, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 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 - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent | Car Transfer - 05. Setup or clean-up assistance<br>Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance<br>Shower/Bathe Self - 03. Partial/moderate assistance<br>Lower Body Dressing - 05. Setup or clean-up assistance<br>Don/Doff Footwear - 05. Setup or clean-up assistance<br>Walk 10 Feet - 04. Supervision or touching assistance<br>Walk 50 ft with 2 Turns - 04. Supervision or touching assistance<br>Toileting Hygiene - 05. Setup or clean-up assistance<br>Upper Body Dressing - 06. Independent<br>Sit to Stand - 05. Setup or clean-up assistance<br>Chair to Bed to Chair - 05. Setup or clean-up assistance<br>Oral Hygiene - 06. Independent<br>Eating - 06. Independent |

| Signature of Physician: | Date |
|---|---|
| | PAGE 3 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles RN | 05/20/2026 |