Home Health Certification and Plan of Care

Order ID: 1150/19036

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
95143638	05/27/2026	From: 05/27/2026 To: 07/25/2026	23740	217058

6. Patient's Name and Address

Kenneth Wallace
3909 Mewswood Ln Apt A1,
NOTTINGHAM, MD 21236-
410-299-6657

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 11/24/1981 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	05/27/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	05/27/26
E11.40	Type 2 diabetes mellitus with diabetic neuropathy unsp	05/27/26
D86.9	Sarcoidosis unspecified	05/27/26
H47.20	Unspecified optic atrophy	05/27/26
M54.12	Radiculopathy cervical region	05/27/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/27/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	05/27/26
D50.9	Iron deficiency anemia unspecified	05/27/26
I10.	Essential (primary) hypertension	05/27/26
H46.9	Unspecified optic neuritis	05/27/26
E66.9	Obesity unspecified	05/27/26
Z68.30	Body mass index [BMI] 30.0-30.9 adult	05/27/26
Z79.82	Long term (current) use of aspirin	05/27/26
Z79.1	Long term (current) use of non-steroidal non-inflam (NSAID)	05/27/26
Z79.891	Long term (current) use of opiate analgesic	05/27/26
Z86.0100	Personal history of colonic polyps	05/27/26
Z87.891	Personal history of nicotine dependence	05/27/26

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

Asa 81 Mg - Aspirin 81mg; 1 tab by mouth twice a day post op right hip
LIPITOR eq 10 mg base 10 mg / 1 Tablet by mouth in the evening for cholesterol and heart protection
APRESOLINE 25 mg 25 mg / 1 Tablet by mouth three times a day HTN
Iron - Ferrous Sulfate: Folic Acid 1 TAB by mouth once a day SUPPLEMENT
COZAAR 100 mg / 1 Tablet by mouth daily HTN
LOPRESSOR 50 mg 50MG; 1 TAB by mouth 2 times a day HTN
Multivitamins Minerals-Folic Acid Vit K-Lycopene (ONE-A-DAY MEN'S MULTIVITAMIN) 400-20-300 mcg / 1 Tablet by mouth once a day SUPPLEMENT
ACETAMINOPHEN 500 mg / 2 TABS by mouth every 8 hours AS NEEDED FOR PAIN
LASIX 20 mg 20 mg / 1 Tablet by mouth every morning AS NEEDED FOR LEG SWELLING
Ibuprofen - Ibuprofen 600 mg 600MG; 1 TAB by mouth every 6 hours AS NEEDED FOR FEVER
COLACE 100 mg / 1 Capsule by mouth 2 times a day (Patient reported not taking: reported on 3/13/2026)
CLARITIN 10 mg / 1 Tablet by mouth daily ALLERGIES
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5MG; 1-2 TANS by mouth every 4 hours AS NEEDED FOR PAIN
ALPHAGAN 0.2 % Opht Drop / Instill 1 Drop in affected eye(s) Ophthalmic twice a day

14. DME and Supplies:

walker, cane

15. Safety Measures:

standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, transfer with assist, hip precautions, activity supervision

16. Nutrition:

cardiac diet,

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Walker, Exercises Prescribed

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: 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

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 44-year-old male referred to home health services following an elective right total hip replacement secondary to avascular necrosis. His past medical history is significant for diabetes mellitus, sarcoidosis, bilateral optic atrophy, binocular vision disorder, cervical radiculopathy, obstructive sleep apnea, anemia, and colon polyps. The patient reports postoperative complications with fever as well as ongoing sciatic and groin discomfort. He is alert and oriented x3, reports pain at 2/10 with last pain medication taken at 10:00 AM, denies shortness of breath, and has clear lung sounds throughout. Appetite is good, bowel movement occurred today, and the right hip dressing remains intact. The patient is wearing compression stockings and ambulates with a rolling walker for safety. Prior to surgery, he experienced significant mobility limitations requiring assistance with transfers, bed mobility, and ADLs. Current assessment reveals continued deficits in bed mobility, transfers, gait, stair negotiation, and activity tolerance, with noted right lower extremity flexor withdrawal and hypertonicity. A neurology consultation was recommended to further evaluate chronic right knee extension difficulty and abnormal tone. The patient resides in a second-floor apartment with his wife and family, requiring negotiation of 16 stairs with railing assistance. Family assists with ADLs and IADLs as needed. Skilled nursing reviewed all medications, including dosage, frequency, and side effects, and provided education on pain management and postoperative care, with the patient and spouse demonstrating understanding. Physical and occupational therapy services are indicated for gait training, strengthening, ADL training, home exercise program development, functional mobility, safety, and fall prevention.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 05/27/2026
 Physician Face-to-Face Date: 05/05/2026
 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right 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<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval Notes: <o:p></o:p> OT 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 Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/27/2026

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 : 05/05/2026

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 (05/27/26-05/30/26) ,WK2: 1 (05/31/26-06/06/26)

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; 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 ; 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.

RIGHT HIP
Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, Home Safety, meal preparation, dependent edema, M1033 - Exhaustion, M1400 - Dyspnea, limited range of motion, poor muscle tone, swelling of affected area, limited strength, limited endurance, balance deficit, Pain Interference with Therapy activities, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Other - RIGHT HIP -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - RIGHT HIP -: 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., 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, patient's living environment is clean/uncluttered, meal preparation is available to patient for all meals

PATIENT-STATED GOAL: TO BE ABLE TO WALK AGAIN WITHOUT THE WALKER

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
* 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
* 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
* 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

patient's living environment is clean/uncluttered

meal preparation is available to patient for all meals

PT Careplans	PT Goals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/27/2026

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PT WK1: 1 (05/27/26-05/30/26) ,WK2: 3 (05/31/26-06/06/26) ,WK3: 2 (06/07/26-06/13/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface

PROCEDURES: Medication management : Meds reviewed with pt and caregiver, home exercise program: Hamstring, gastroc, and hip flexor stretching, 20 Second holds, AA for hip flexion, laq, heelraises, GS, aps, QS, equipment training, work simplification/energy conservation, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 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, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 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 - 05. Setup or clean-up assistance, 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, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: To improve my flexibility and strength be able to walk amd get down steps easier

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

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

Toilet Transfer - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 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

Car Transfer - 05. Setup or clean-up assistance

Oral Hygiene - 05. Setup or clean-up assistance

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

Upper Body Dressing - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

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

OT Careplans

OT WK2: 1 (05/31/26-06/06/26) ,WK4: 1 (06/14/26-06/20/26) ,WK6: 1 (06/28/26-07/04/26) ,WK8: 1 (07/12/26-07/18/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing

PROCEDURES: cough/deep breathing exercises, home exercise program: Red theraband: bilateral shoulder, flex, abd, horizontal abd/add, elbow flex/ext 2x10 reps, equipment training, work simplification/energy conservation, transfers training: Tub, toilet, transfers training: Tub, toilet, transfers training: Tub, toilet, transfers training: Tub, toilet

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, Oral Hygiene - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: To walk better

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/27/2026