Home Health Certification and Plan of Care

Order ID: 1150/20091

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
91151918	06/26/2026	From: 06/26/2026 To: 08/24/2026	26785	217058

6. Patient's Name and Address

Miroslav Havel
7245 Riding Hood Cir,
COLUMBIA, MD 21045-
443-617-2496

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 06/08/1961 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	06/26/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	06/26/26
I10.	Essential (primary) hypertension	06/26/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	06/26/26
E03.9	Hypothyroidism unspecified	06/26/26
F39.	Unspecified mood [affective] disorder	06/26/26
D23.9	Other benign neoplasm of skin unspecified	06/26/26
E04.1	Nontoxic single thyroid nodule	06/26/26
M54.16	Radiculopathy lumbar region	06/26/26
Z86.711	Personal history of pulmonary embolism	06/26/26
Z79.01	Long term (current) use of anticoagulants	06/26/26

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

Colace - Docusate Sodium 100mg; 1 cap by mouth twice a day bowel regimen
Synthroid - Levothyroxine Sodium 150 MCG / 1 Tablet by mouth every morning 30 minutes before a meal
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 2000 IU; 1 TAB by mouth once a day SUPPLEMENT
PRADAXA 150 mg 150 MG / 1 Capsule by mouth every 12 hours BLOOD THINNER
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5MG; 1-2 TABS by mouth every 4 hours AS NEEDED FOR PAIN
Acetaminophen - Acetaminophen 500MG; 1-2 TABS by mouth as necessary FOR PAIN

14. DME and Supplies:

walker, cane

15. Safety Measures:

standard precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, ambulates with assistance, supervision at all times, , , hip precautions, anticoagulant precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED 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: 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: 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
family/caregiver 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 65-year-old male admitted to home health services following a right total hip replacement performed on 06/25/2026. His past medical history is significant for hypothyroidism, mood disorder, obstructive sleep apnea (OSA), lumbar radiculopathy, thyroid nodule, and a history of pulmonary embolism for which he is prescribed Pradaxa (dabigatran). The plan of care includes skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> once weekly for two weeks (1W2) and skilled physical therapy evaluation and treatment. Upon skilled nursing assessment, the patient was alert and oriented to person, place, and time (A&O 3). He reported right hip pain rated 3/10, with his last dose of prescribed oxycodone taken approximately two hours prior to the visit. The patient denied shortness of breath, and pulmonary assessment revealed lungs clear to auscultation bilaterally. The patient reported no bowel movement since prior to surgery. Assessment of the surgical site demonstrated the right hip dressing to be clean, dry, intact, and securely in place without evidence of drainage or other signs of postoperative complications. The patient was wearing TED compression stockings as prescribed and was ambulating with a rolling walker to promote safety and maintain adherence to postoperative precautions. Vital signs were assessed and remained within acceptable parameters. A comprehensive medication reconciliation and review were completed. Skilled nursing provided education regarding all prescribed medications, including indications, dosages, administration schedules, and potential side effects, with particular emphasis on anticoagulation therapy with Pradaxa and the importance of recognizing and promptly reporting signs and symptoms of bleeding. Postoperative education included reinforcement of hip precautions, incision care, pain management strategies, prevention of constipation associated with opioid use through adequate hydration, dietary fiber intake, activity as tolerated, and use of prescribed bowel medications if indicated. Additional education focused on fall prevention, safe use of the rolling walker, recognition of signs and symptoms of infection, venous thromboembolism prevention, adherence to compression stocking use, and the importance of attending all scheduled follow-up appointments. Both the patient and spouse verbalized understanding of all education provided. Physical therapy evaluation revealed postoperative right hip pain, right lower extremity weakness, impaired balance, altered gait mechanics, and decreased functional endurance. These impairments contribute to difficulty with bed mobility, requiring increased time and compensatory techniques; impaired sit-to-stand transfers requiring upper extremity support and assistance for safety; and limited household ambulation due to an antalgic gait pattern, decreased endurance, and reliance on a rolling walker. The patient also demonstrates reduced stair negotiation tolerance, impacting safe access to and from the home environment. These functional limitations support the patient's homebound status, as leaving the home requires considerable and taxing effort and assistance. Continued skilled nursing services are medically necessary for ongoing postoperative assessment, medication management, pain assessment, incision monitoring, reinforcement of patient education, and surveillance for signs of infection, bleeding, or other postoperative complications. Skilled home health physical therapy is medically necessary to improve lower extremity strength, balance, gait mechanics, transfer ability, endurance, and stair negotiation while providing pain management strategies and safety education. The overall goal of care is to promote safe postoperative recovery, maximize functional independence, reduce fall risk, prevent complications and rehospitalization, and facilitate the patient's return to his prior level of function.
 Date of Order 06/26/2026 Orders Physician Face-to-Face Date: 06/12/2026 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 <span

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/26/2026

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 : 06/12/2026

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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style="font-size: 14px;">Narcisse, Patrick

SN Careplans

SN WK1: 1 (06/26/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26)

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: 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; 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:No

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, limited strength, limited range of motion, limited endurance, balance deficit, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, bruising/discoloration, #1 - Non-Observable Surgical Wound - Anterior Right Hip - right hip dressing intact; no drainage noted

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Hip - right hip dressing intact; no drainage noted: SN TO REMOVE RIGHT HIP DRESSING POST OP DAY 7, cough/deep breathing exercises, incentive spirometer, apply compression bandage

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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

SN Goals

PATIENT-STATED GOAL: TO HAVE BALANCE AND WALK BETTER

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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (06/26/26-06/27/26) ,WK2: 2 (06/28/26-07/04/26) ,WK3: 3 (07/05/26-07/11/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170O1 - 12 Steps, GG0130F1 - Upper Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, GG0170D1 - Sit to Stand, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer

PT Goals

PATIENT-STATED GOAL: to have a successful post surgical outcome

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/26/2026

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PROCEDURES: B LE mm strengthening: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
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