Home Health Certification and Plan of Care

Order ID: 1150/20236

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
47311041	07/03/2026	From: 07/03/2026 To: 08/31/2026	18216	217058

6. Patient's Name and Address

Michael Martel
907 Gladway Rd,
MIDDLE RIVER, MD 21220-
410-599-3077

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 10/11/1960 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	07/03/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	07/03/26
M17.0	Bilateral primary osteoarthritis of knee	07/03/26
M19.012	Primary osteoarthritis left shoulder	07/03/26
J84.10	Pulmonary fibrosis unspecified	07/03/26
J43.9	Emphysema unspecified	07/03/26
N28.1	Cyst of kidney acquired	07/03/26
K76.9	Liver disease unspecified	07/03/26
E78.00	Pure hypercholesterolemia unspecified	07/03/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/03/26
Z79.01	Long term (current) use of anticoagulants	07/03/26
Z79.891	Long term (current) use of opiate analgesic	07/03/26
Z98.1	Arthrodesis status	07/03/26
Z86.718	Personal history of other venous thrombosis and embolism	07/03/26
Z87.891	Personal history of nicotine dependence	07/03/26
Z87.01	Personal history of pneumonia (recurrent)	07/03/26

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

Artificial Tears - Normal Saline Instill 1 drop in both eyes both eyes three times a day Instill 1 drop in both eyes three times a day for Dry eyes for 7 Days.
1-2 drops in right eyes as needed
Ibuprofen - Ibuprofen 400 MG, Give 1 tablet by mouth every 8 hours Give 1 tablet by mouth every 8 hours as needed for pain 6-10
Mylanta - Simethicone 400-400-40 MGV5ML, Give 30 ml by mouth every 12 hours Give 30 ml by mouth every 012 hours as needed for upset stomach
Polyethylene Glycol - Polyethylene Glycol 3350: Potassium Chloride: Sodium Bicarbonate: Sodium Chloride Give 17-gram, powder by mouth once a day Give 17 gram by mouth one time a day for hold for lose stool
One A Day Vitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 60 tablets by mouth once a day Daily supplement
Amilodipine - Amlodipine Besylate 5 MG, Give 1 tablet by mouth once a day Tablet 5 MG Give 1 tablet by mouth one time a day for HTN Hold for SBP lower than 100mmHg and notify MD
Acetaminophen - Acetaminophen 500 MG, Give 2 tablet by mouth every 6 hours Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for Pain 1-5 *Use caution wV APAP total daily dose greater than 3,000mg*
Melatonin - Melatonin 3 MG Give 1 tablet by mouth as necessary Give 1 tablet by mouth every 24 hours as needed for insomina to be administered at bedtime
Eliquis - Apixaban 5 MG, Give 1 tablet by mouth twice a day Give 1 tablet by mouth two times a day for Afib
Protonix - Pantoprazole Sodium eq 40 mg base 40 MG Give 1 tablet by mouth once a day Give 1 tablet by mouth one time a day for GERD
Dulcolax - Bisacodyl 354ml by mouth as necessary As needed for constipation
Methadone - Methadone Hydrochloride Give 105 mg by mouth once a day Give 105 mg by mouth one time a day for Opioid dependence
Gabapentin - Gabapentin 600 mg 600 by mouth three times a day Sometimes I take 2x a day and other times 3x a day depending on pain lev
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 4 hours Post surgery
Colace - Docusate Sodium 100mg by mouth twice a day 1-2 tabs for stool softners
Albuterol Sulfate And Ipratropium Bromide - Albuterol Sulfate: Ipratropium Bromide take 0.5-2.5, inhale inhalant in the morning inhale orally in the morning for SOB or Wheezing via nebulizer

14. DME and Supplies:

walker, cane, 4 wheeled walker

15. Safety Measures:

walker precautions, supervision at all times, standard precautions, no bending, hip precautions, fall precautions, bleeding precautions, bathroom safety, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

low sodium, ,

17. Allergies:

no known allergies

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Ambulation, Endurance!Paralysis

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: No

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
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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/03/2026

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 : 06/19/2026

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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Clinical Condition Requiring Homecare:

The patient is a 65-year-old male admitted to home health services following an elective right total hip replacement (RTHR). He returned home the same day as surgery with assistance from family. The patient is homebound due to his recent right hip joint replacement, requiring a walker with one-person supervision for all mobility, making it a considerable and taxing effort to leave the home safely. He remains at high risk for falls secondary to postoperative pain, impaired mobility, bilateral lower extremity limitations, and significant functional deficits. Physical therapy assessment revealed postoperative right hip pain, decreased range of motion, reduced lower extremity strength, ambulatory dysfunction, impaired balance, deficits in bed mobility and transfers, and impaired gait mechanics. The patient requires assistance for all functional mobility and ambulates with a rollator using a discontinuous step pattern. He relies heavily on the rollator to offload his lower extremities during gait, landing primarily on his forefeet due to bilateral hip weakness and pain. The patient demonstrates marked limitations of the left lower extremity related to advanced left hip osteoarthritis, preventing him from leading with the left lower extremity during stair negotiation. He was only able to negotiate a single step by leading with the right lower extremity. Due to severe balance impairment, the Timed Up and Go (TUG) test could not be safely performed. The patient scored 2/28 on the Tinetti Balance and Gait Assessment, indicating an extremely high risk for falls. Skin assessment identified two blisters on the right distal lower extremity just below the knee, including a newly observed blister measuring approximately 2.4 cm 1.2 cm. The findings were reviewed with the patient's sister, who is actively assisting with his care. Education was provided to the patient and caregiver regarding edema management, proper lower extremity positioning, anterior total hip precautions, pain management strategies, and recognition of signs and symptoms of infection, including increased redness, warmth, swelling, drainage, fever, or worsening pain. The patient's sister reported that the patient did not tolerate oxycodone well and prefers that it not be used for pain management. Both the patient and caregiver demonstrated understanding of the education provided. A home exercise program was initiated, including ankle pumps, long arc quadriceps exercises, quadriceps sets, and gluteal sets to improve strength, circulation, and functional recovery. Skilled home health physical therapy is medically necessary to address postoperative pain, restore lower extremity strength and range of motion, improve gait mechanics, balance, transfers, bed mobility, stair negotiation, and overall functional mobility while reinforcing hip precautions and fall prevention strategies. Continued skilled intervention is essential to reduce the risk of falls, prevent postoperative complications and further functional decline, maximize independence, and facilitate a safe recovery following right total hip replacement surgery.
 Date of Order 07/03/2026 Orders Physician Face-to-Face Date: 06/19/2026 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 Narcisse, Patrick

SN Careplans

SN WK1: 1 (07/03/26-07/04/26) ,WK2: 1 (07/05/26-07/11/26)

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

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.

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.
Advance Directive:Na

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, abnormal blood pressure, M1400 - Dyspnea, heartburn/indigestion, swelling of affected area, limited

SN Goals

PATIENT-STATED GOAL: To be to able d4ive, walk outside

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

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/03/2026

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endurance, limited range of motion, pain radiating to arms/legs, balance deficit, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, swell/redness surround. skin, red/tender pressure points, #1 - Non-Observable Surgical Wound - Anterior Right Hip -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior 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., cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, physician-ordered wound care: 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., monitor intake & output, coordinate/arrange preparation of missing meals

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, meal preparation is available to patient for all meals

PT Careplans

PT WK2: 3 (07/05/26-07/11/26) ,WK3: 3 (07/12/26-07/18/26)

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, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170P1 - Picking Up Object, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, #2 - Blister - Anterior Right Below Knee - Blister ant-lat aspect just distal to R knee it is intact Ed to pt amd caregiver to not attempt to pop it

PROCEDURES: physician-ordered wound care: #2 - Blister - Anterior Right Below Knee - Blister ant-lat aspect just distal to R knee it is intact Ed to pt amd caregiver to not attempt to pop it, physician-ordered wound care: Currently open ot air, physician-ordered wound care: Currently open to air, physician-ordered wound care: Currently open ot air, home exercise program: Supine QS, Heelslides with assist, GS, aps, laq, hip flexion to 90 degrees, heelraises, toe raises laq, hamstring curls, equipment training, work simplification/energy conservation, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, 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

PT Goals

PATIENT-STATED GOAL: To improve walking be able to use the steps again

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

4 Steps - 04. Supervision or touching assistance

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

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/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

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/03/2026