Home Health Certification and Plan of Care

Order ID: 1150/20823

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
871072086	07/24/2026	From: 07/24/2026 To: 09/21/2026	27746	217058

6. Patient's Name and Address

Paulette Horrey
8 Powhurst Ct,
BALTIMORE, MD 21236-
443-602-2995

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 08/03/1951 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	07/24/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	07/24/26
I10.	Essential (primary) hypertension	07/24/26
M54.42	Lumbago with sciatica left side	07/24/26
E55.9	Vitamin D deficiency unspecified	07/24/26
E78.5	Hyperlipidemia unspecified	07/24/26
R73.03	Prediabetes	07/24/26
Z90.710	Acquired absence of both cervix and uterus	07/24/26
Z87.891	Personal history of nicotine dependence	07/24/26

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

MOBIC 15 MG / 1 Tablet by mouth daily
ROXICODONE 5 mg/tablet / Take 1 - 2 tablets by mouth every 4 hours as needed for pain
ECOTRIN 0 Delayed Release 81 MG / 1 Tablet by mouth 2 times a day
COLACE 100 MG / 1 Capsule by mouth 2 times a day Stool softener
TYLENOL 500 MG / 1 Tablet by mouth every 6 hours as needed
NORVASC 10 MG / 1 Tablet by mouth daily HTN
Zestoretic - Hydrochlorothiazide: Lisinopril 20 12.5 mg/tablet / Take 2 tablets by mouth daily
LIPITOR 40 MG / 1 Tablet by mouth daily for cholesterol and heart protection
MULTI-VITAMIN - by mouth not available

14. DME and Supplies:

bath bench, walker, cane

15. Safety Measures:

standard precautions, fall precautions, ambulates with device, walker precautions, medication safety, hip precautions, bathroom safety

16. Nutrition:

low sodium

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

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: 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

patient will be responsible for managing treatment

Homebound status: After undergoing Left 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 74-year-old female admitted to home health services following a left total hip replacement. Her past medical history is significant for osteoarthritis of the left hip, hypertension, hyperlipidemia, low back pain with left-sided sciatica (lumbago with sciatica), sinus bradycardia, chronic left knee pain, facial skin lesion, and history of hysterectomy. The patient lives alone in a townhouse with seven steps to enter the home, while the bedroom and bathroom are located in the basement. Her daughter is currently serving as her primary caregiver during her postoperative recovery. Upon skilled nursing assessment, the patient was alert and oriented with vital signs within normal limits. Respirations were even and unlabored. The patient reported experiencing persistent nausea and vomiting after taking prescribed oxycodone for postoperative pain management. She stated that she vomited twice after taking the medication and again after attempting to eat eggs and toast as instructed by the surgical nurse during a follow-up call. During the home visit, the patient experienced another episode of nausea with vomiting. The surgeon was promptly notified, and an order for Zofran (ondansetron) was obtained to manage her symptoms. The patient's daughter agreed to pick up the medication from the pharmacy. The patient was observed wearing compression stockings and managing postoperative swelling with regular ice application. The surgical site was monitored, and no acute concerns were reported during the visit. Comprehensive skilled nursing education was provided regarding medication compliance, appropriate use of antiemetic and pain medications as prescribed, recognition of medication side effects, incision care, signs and symptoms of infection, edema management with compression stockings and ice therapy, constipation prevention related to opioid use, adequate hydration and nutrition, fall prevention strategies, and the importance of adhering to the prescribed home exercise program and activity recommendations. The patient and caregiver verbalized understanding of the education provided. A skilled home health physical therapy evaluation was completed due to postoperative functional decline following left total hip replacement. The patient presents with decreased lower extremity strength, impaired balance, altered gait mechanics, decreased endurance, and reduced functional mobility requiring skilled intervention. She ambulates approximately 30 feet twice on level indoor surfaces using a rolling walker with supervision and verbal cueing for proper gait pattern. She is able to negotiate 14 stairs using a handrail and cane with supervision and cueing for safe sequencing and technique. Transfers to the bed, chair, and toilet require supervision with verbal cues to extend the left lower extremity before sitting to maintain hip precautions. Bed mobility is performed with supervision and instruction to maintain appropriate lower extremity positioning and avoid crossing the legs. Therapeutic exercises, including supine quadriceps sets, gluteal sets, hip flexion, bridging, seated knee extensions, and ankle pumps, were initiated with 10 repetitions each using verbal cues for proper technique. Written home exercise instructions were provided, and the patient was instructed to perform the exercises twice daily. Additional education included applying ice to the left hip for 20 minutes several times daily, ambulating with a rolling walker at least five times daily, and avoiding use of a cane except when negotiating stairs. The patient remains homebound due to the considerable and taxing effort required to leave the home, dependence on an assistive device, impaired mobility, postoperative weakness, and increased fall risk, as evidenced by a Tinetti Balance and Gait Assessment score of 14/28. Skilled nursing and physical therapy services remain medically necessary to monitor postoperative recovery, manage symptoms, provide ongoing education, improve strength, balance, gait, and functional mobility, reduce fall risk, and facilitate a safe return to her prior level of independence.
 Date of Order 07/24/2026 Orders Physician Face-to-Face Date: 07/09/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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 Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/24/2026

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 : 07/09/2026

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 (07/24/26-07/25/26) ,WK2: 1 (07/26/26-08/01/26)

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; 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

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, abnormal blood pressure, M1033 - Exhaustion, M1400 - Dyspnea, nausea/vomiting, limited strength, balance deficit, Pain Interference with ADLs, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Left Hip - left hip surgical site

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Hip - left hip surgical site: Left hip surgical site: Remove aquacel dressing on the 7th day post op and LOTA, otherwise cover with dry gauze 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

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
* 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: 1 (07/24/26-07/25/26) ,WK2: 3 (07/26/26-08/01/26) ,WK3: 2 (08/02/26-08/08/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, 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, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface, 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, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PT Goals

PATIENT-STATED GOAL: To be able to get around the house by myself with my cane and return to driving

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

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

07/24/2026

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PROCEDURES: Bed mobility training : Sit to supine and supine to sit following hip precautions, Hip precautions training : Keep legs apart, no flexion greater than 90 degrees, no leg crossing, home exercise program: supine quad sets, glut sets, hip flexion, bridging. Sitting knee extension and ankle pumps. Standing knee flexion, hip abduction, plantarflexion, squats 10x each with cues for technique. Written instructions were issued and instructed to perform 2x daily 10x each., home exercise program: supine quad sets, glut sets, hip flexion, bridging. Sitting knee extension and ankle pumps. Standing knee flexion, hip abduction, plantarflexion, squats 10x each with cues for technique. Written instructions were issued and instructed to perform 2x daily 10x each., home exercise program: supine quad sets, glut sets, hip flexion, bridging. Sitting knee extension and ankle pumps. Standing knee flexion, hip abduction, plantarflexion, squats 10x each with cues for technique. Written instructions were issued and instructed to perform 2x daily 10x each. Tolerated start. Progress to 20 x, equipment training, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * 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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 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, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 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 - 02. Substantial/maximal assistance, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent

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

Picking Up Object - 04. Supervision or touching assistance

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

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

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

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/24/2026