Home Health Certification and Plan of Care

Order ID: 1150/20820

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
42297259	07/24/2026	From: 07/24/2026 To: 09/21/2026	27744	217058

6. Patient's Name and Address
Monica Collins
8375 Kings Heights Rd,
ELLICOTT CITY, MD 21043-
443-386-5651

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 03/09/1956 **9.Sex** Female

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

13. ICD	Other Pertinent Diagnoses	Date
Z96.641	Presence of right artificial hip joint	07/24/26
I10.	Essential (primary) hypertension	07/24/26
E78.5	Hyperlipidemia unspecified	07/24/26
M85.80	Oth disrd of bone density and structure unspecified site	07/24/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/24/26
H40.033	Anatomical narrow angle bilateral	07/24/26
Z79.82	Long term (current) use of aspirin	07/24/26
Z87.891	Personal history of nicotine dependence	07/24/26

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

ECOTRIN 2 Delayed Release 81 MG tablet by mouth daily For 10 days
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 125 mcg (5,000 unit) Tab / Take 5,000 Units by mouth daily
PEPCID 40 MG / 1 Tablet by mouth daily GERD
HYZAAR 100-25 MG / 1 Tablet by mouth daily HTN
Centrum Silver - Ascorbic Acid: Biotin: Cyanocobalamin: Ergocalciferol: Folic Acid: Niacinamide: Pantothenic Acid: Phytonadione: Pyridoxine: Ribo 0.4 mg-300 mcg- 250 mcg / 1 Tablet by mouth daily Supplement
Colace - Docusate Sodium 100mg by mouth twice a day
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth as necessary 1-2 tabs Every 4 hours. Only taking one at a time

14. DME and Supplies:
bath bench, walker

15. Safety Measures:
walker precautions, fall precautions, medication safety, hip precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
No Known Allergies

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
Walker, 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: 1. Rarely, 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
family/caregiver will be responsible for managing treatment
patient 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 70-year-old female admitted to home health services following a right total hip replacement. Her past medical history is significant for hypertension, right hip arthritis, and other comorbidities. Upon arrival for the admission visit, the patient was seated comfortably in a chair with her spouse present and actively participating in her care. She was alert and oriented to person, place, time, and situation (A&O 4) and denied pain, shortness of breath, chest pain, nausea, or other acute complaints. The patient reported her last bowel movement occurred the day prior to surgery and denied any difficulty with urination since returning home. A comprehensive physical assessment was completed, and vital signs were obtained and found to be within normal limits. Lung sounds were clear to auscultation bilaterally, bowel sounds were present in all four quadrants, and no peripheral edema was noted. Assessment of the right hip surgical site revealed the postoperative dressing to be clean, dry, and intact with no evidence of drainage or signs of infection. <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-2 CE-FMS-Medications">Medications</mh> were reviewed and reconciled, and the home health admission process was completed. Skilled nursing provided education regarding postoperative hip precautions, medication adherence, incision care, recognition of signs and symptoms of infection and other postoperative complications, bowel management to prevent constipation, fall prevention strategies, adequate hydration and nutrition to promote healing, and instructions on when to notify the physician or seek emergency medical care. The patient and spouse verbalized understanding of all education provided. The patient was referred for skilled home health physical therapy evaluation due to functional decline following right total hip replacement. She presents with bilateral lower extremity weakness, impaired gait mechanics, decreased balance, reduced endurance, impaired functional mobility, and requires assistance for safe transfers and ambulation during postoperative recovery. Skilled physical therapy is medically necessary to provide therapeutic exercises for lower extremity strengthening, gait retraining, transfer training, balance and endurance training, functional mobility activities, instruction in the safe use of assistive devices, and development of an individualized home exercise program. The goal of therapy is to maximize functional independence, improve mobility and safety, reduce fall risk, facilitate healing, and enable the patient to safely return to her prior level of function while remaining in her home environment.
 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 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 (07/24/26-07/25/26) ,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

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if

SN Goals

PATIENT-STATED GOAL: "I want the incision to heal."

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

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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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, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, muscle weakness, limited range of motion, limited strength, balance deficit, Pain Effect on Sleep, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Anterior Right Hip -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Hip -, cough/deep breathing exercises, incentive spirometer, coordinate/arrange for adequate patient supervision

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, patient is adequately supervised, caregiver performs medical/rehabilitation treatments with adequate competence

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

patient is adequately supervised

caregiver performs medical/rehabilitation treatments with adequate competence

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 Therapy activities, 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, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, 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, GG0170D1 - Sit to Stand

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: * 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,

PT Goals

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

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

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

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Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent	Walk 150 Feet - 05. Setup or clean-up assistance 4 Steps - 05. Setup or clean-up assistance 12 Steps - 05. Setup or clean-up assistance Picking Up Object - 05. Setup or clean-up assistance Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Shower/Bathe Self - 06. Independent Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent

Signature of Physician:	Date
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