Home Health Certification and Plan of Care

Order ID: 1150/20968

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
36347524	07/29/2026	From: 07/29/2026 To: 09/26/2026	27845	217058

6. Patient's Name and Address

Joanne Campbell
1028 Chesapeake Dr Apt 5C,
HAVRE DE GRACE, MD 21078-
732-754-6408

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 12/02/1956 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	07/29/26

13. ICD	Other Pertinent Diagnoses	Date
M17.0	Bilateral primary osteoarthritis of knee	07/29/26
E78.5	Hyperlipidemia unspecified	07/29/26
M85.80	Oth disrd of bone density and structure unspecified site	07/29/26
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	07/29/26
G47.00	Insomnia unspecified	07/29/26
E03.9	Hypothyroidism unspecified	07/29/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/29/26
N39.3	Stress incontinence (female) (male)	07/29/26
Z96.642	Presence of left artificial hip joint	07/29/26
Z87.891	Personal history of nicotine dependence	07/29/26

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

TYLENOL 500 mg , Take 2 tablets by mouth every 6 hours as needed For pain
Synthroid - Levothyroxine Sodium 75 MCG / 1 Tablet by mouth every morning 30 minutes before a meal
ROXICODONE 5 mg/tablet / Take 1 to 2 tablets by mouth every 4 hours as needed for pain.
MOBIC 15 MG / 1 Tablet by mouth daily For pain
MELATONIN 5 MG Tablet by mouth at bedtime as needed (sleep)
Calcium Carbonate-Vit D3 (CALCIUM 500+D) Oral Chew Tab 500 mg-10 mcg (400 unit) / Chew and swallow 1 tablet by mouth once a day
ECOTRIN 0 LOW STRENGTH 81 MG / 1 Tablet by mouth twice a day
DITROPAN 5 MG / 1 Tablet by mouth daily
COLACE 100 MG / 1 Capsule by mouth 2 times a day

14. DME and Supplies:

rolling walker, hand held shower, bath bench, walker, grab bars, 4 wheeled walker

15. Safety Measures:

standard precautions, hand rails, fall precautions, bleeding precautions, ambulates with device, walker precautions, restricted ROM, medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, bathroom safety, activity supervision

16. Nutrition:

regular

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Exercises Prescribed, 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: 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 arthroplasty, 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 69-year-old female referred to home health services following an elective anterior left total hip arthroplasty performed for advanced osteoarthritis. Her past medical history is significant for dyslipidemia/hyperlipidemia, osteopenia, osteoarthritis of both knees, diverticulitis of the colon, hypothyroidism, gastroesophageal reflux disease (GERD), insomnia, and a history of smoking. Prior to surgery, the patient was independent with all activities of daily living and instrumental activities of daily living, ambulated independently without an assistive device, drove, and functioned independently within the community. She returned home the same day of surgery with family assistance and currently resides with her husband in an apartment building requiring negotiation of 10 steps with one handrail to enter the home. On assessment, the patient is alert, oriented to person, place, time, and situation (A&O 4), medically stable, and demonstrates a positive outlook regarding her recovery. Lung sounds are clear to auscultation bilaterally, bowel sounds are active in all quadrants, and medications were reviewed and reconciled with the patient. She reports left hip pain rated at 4/10, which is adequately managed with Tylenol, oxycodone, and meloxicam. Mild postoperative swelling of the left lower extremity is present. The patient is taking aspirin for deep vein thrombosis (DVT) prophylaxis and was instructed on the importance of medication adherence. Education was also provided regarding routine use of docusate (Colace) to prevent opioid-induced constipation. The patient verbalized understanding of all medication instructions. The patient currently ambulates using two canes and reports that although she has a walker available, she finds it difficult to maneuver within her living room due to space limitations. Assessment reveals postoperative pain, decreased left hip range of motion and strength, impaired balance, ambulatory dysfunction, impaired bed mobility, transfer deficits, and decreased overall functional mobility. She requires assistance with mobility and is considered at high risk for falls. The anterior total hip replacement precautions were reviewed, and the patient demonstrated understanding. Skilled instruction was provided on edema management, including proper lower extremity positioning, regular application of ice, and consistent use of thigh-high compression stockings to minimize postoperative swelling. The patient was also educated on recognizing the signs and symptoms of surgical site infection, including increased redness, swelling, warmth, drainage, fever, or worsening pain, and instructed to notify her healthcare provider immediately should these occur. A home exercise program was initiated consisting of ankle pumps, quadriceps sets, and gluteal sets, performing 1-2 sets of 10 repetitions as tolerated to improve circulation, strength, and functional recovery. The patient presents with significant postoperative impairments in strength, range of motion, balance, gait, transfers, and functional mobility following left total hip arthroplasty. Skilled home physical therapy is medically necessary to improve mobility, restore strength and range of motion, reinforce adherence to hip precautions, improve transfer and gait safety, reduce fall risk, and maximize independence with activities of daily living. Without skilled physical therapy intervention, the patient remains at increased risk for falls, postoperative complications, functional decline, and loss of independence. The patient is considered homebound due to postoperative pain, impaired mobility, decreased endurance, high fall risk, and the considerable effort and assistance required to safely leave the home.
 Date of Order 07/29/2026 Orders Physician Face-to-Face Date: 07/10/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control, PT-eval & treat due to Left total hip arthroplasty 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 07/29/2026

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 : 07/10/2026

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 (07/29/26-08/01/26) ,WK2: 1 (08/02/26-08/08/26)

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: 2. Non-agency caregiver(s) need training/supportive services to 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:Yes

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2020 - Oral Med Management, M2102f - Patient Supervision, Home Safety, M1400 - Dyspnea, M1033 - Exhaustion, dependent edema, abnormal thyroid <> 0.40 - 4.50 mIU/mL, M1610 - Urinary Incontinence, muscle weakness, limited endurance, limited strength, Pain Interference with ADLs, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Left Hip - Left hip replacement surgery, swell/redness surround. skin, bruising/discoloration

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Hip - Left hip replacement surgery: Left hip surgical site: Remove Aquacel dressing on the left hip on the 7th day post op and LOTA. Otherwise cover with a dry 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, * urinary incontinence management including bladder training Kegel exercises skin care, 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 home enviroment has adequate fire safety devices, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PATIENT-STATED GOAL: To get back on my feet.

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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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

patient home enviroment has adequate fire safety devices

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

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	07/29/2026

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PT WK1: 2 (07/29/26-08/01/26) ,WK2: 3 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, 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: Medication management : Review medication with pt, cough/deep breathing exercises, incentive spirometer, home exercise program: Ankle pumps knee extension gluteal sets Standing in the Walker or kitchen counter for a hip flexion on left lower extremity hamstring curls on left lower extremity., equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 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, 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 - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: To get back to walking , long walks outside , get back to doing yoga;To get back to walking , long walks outside , get back to doing yoga;To get back to walking , long walks outside , get back to doing yoga;To get back to walking , long walks outside , get back to doing yoga

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

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

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

Shower/Bathe Self - 03. Partial/moderate assistance

Don/Doff Footwear - 06. Independent

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 - 06. Independent

Lower Body Dressing - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
07/29/2026