Home Health Certification and Plan of Care

Order ID: 1150/11603

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
19130746	08/22/2025	From: 08/22/2025 To: 10/20/2025	16081	217058

6. Patient's Name and Address

Deborah Haegerich
232 Glen Rd,
PASADENA, MD 21122-
410-279-9088

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 02/07/1951 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	08/22/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	08/22/25
M17.11	Unilateral primary osteoarthritis right knee	08/22/25
I10.	Essential (primary) hypertension	08/22/25
E78.5	Hyperlipidemia unspecified	08/22/25
E55.9	Vitamin D deficiency unspecified	08/22/25
F32.A	Depression unspecified	08/22/25
K21.9	Gastro-esophageal reflux disease without esophagitis	08/22/25
R06.83	Snoring	08/22/25
E66.9	Obesity unspecified	08/22/25
Z68.36	Body mass index [BMI] 36.0-36.9 adult	08/22/25
Z85.3	Personal history of malignant neoplasm of breast	08/22/25
Z87.442	Personal history of urinary calculi	08/22/25
Z91.81	History of falling	08/22/25

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

Prinivil - Lisinopril 10 mg, Take 1 tablet by mouth once a day
Tenormin - Atenolol 25 mg, Take 2 tablets by mouth in the morning Take 2 tablets
by mouth every
morning for
hypertension
Norvasc - Amlodipine Besylate 5 mg, Take 1 tablet by mouth once a day
Take 1 tablet
by mouth daily
(PLEASE
SCHEDULE A
FOLLOW UP
VISIT WITH US
SOON).
Lipitor - Atorvastatin Calcium 40 mg, Take 1 tablet by mouth once a day
Take 1 tablet
by mouth daily
for cholesterol
and heart
protection
Protonix - Pantoprazole Sodium 40 mg, Take 1 tablet by mouth once a day
Take 1 tablet
by mouth daily
, use sparingly
Lexapro - Escitalopram Oxalate 20 mg, Take 1 tablet by mouth once a day
Timoptic - Timolol Maleate 0.5 % Opht Drop Instill 1 Drop left eye once a day
Instill 1 Drop in
left eye daily
For 1 week
Ibuprofen - Ibuprofen 600 mg 1 tab by mouth every 6 hours For pain
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg 1-2 tabs by mouth every 4 hours For pain
Aspirin 81Mg - Aspirin 1 tab by mouth once a day Clot prevention
Extra Strength Tylenol - Acetaminophen 500 mg, Take 2 tablet (1,000 mg total) by mouth as necessary For pain
Probiotic Fiber Gummies 2 gummies by mouth once a day Supplement
Fiber Therapy 1 cap by mouth once a day Supplement
Magnesium Oxide - Simethicone 400 mg by mouth once a day Supplement
Docusate Sodium - Docusate Sodium 100 mg I tab by mouth twice a day Constipation
Vitamin B Complex 1 tab by mouth once a day Supplement
Vitamin C - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tab by mouth once a day Supplement

14. DME and Supplies:

grab bars, bath bench, rolling walker

15. Safety Measures:

medication safety, infectious material management, , walker precautions, standard precautions, no straining, knee precautions, fall precautions, bathroom safety, ambulates with assistance, ambulates with device

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Exercises Prescribed, 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: Yes

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: 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 Left Total Knee 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 SN RN on 08/22/2025

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 : 08/04/2025

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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Deborah Haegerich 232 Glen Rd, PASADENA, MD 21122- 410-279-9088	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Clinical Condition Requiring Homecare:

The patient is a 74-year-old female with a history of left knee osteoarthritis, status post left total knee replacement on 8/21/25, discharged home the same day with spousal and family support. On assessment, she is alert and oriented 3, resting comfortably in a recliner, denies chest pain or shortness of breath, and reports surgical-site pain at 6/10; pain is managed with prescribed medications. A cold therapy unit is in use as directed, and a non-removable postoperative dressing is dry and intact with removal planned for 8/29/25. She reports a bowel movement yesterday without complications, is on a bowel regimen, and was educated on the use of docusate. There is no swelling of the bilateral lower extremities, and TED stockings are in place as prescribed. Medications were reconciled with no missing doses or refills needed; admission paperwork and consents were obtained, and the patient agrees with the plan of care. The physical therapy evaluation identifies decreased endurance and mobility with increased fall risk; the patient requires assistance from another person and an assistive device (walker) to safely leave home. Deficits include knee/hip pain, reduced knee strength, impaired functional mobility and transfers, difficulty negotiating steps, unsteady gait, decreased balance and safety awareness, and a history of falls. Education was provided on edema management (including leg elevation above heart level and compression if recommended by the physician), signs and symptoms of wound infection, fall prevention and home safety, and effective pain management (including taking analgesics at pain onset and 1 hour before PT sessions, and monitoring for dizziness and constipation). She was instructed and cued in safe transfers with a walker (requiring minimal assist to standby assist), bed mobility techniques (requiring minimal to moderate assist), and level-surface ambulation with a walker (requiring standby assist); a walking program was initiated with short walks every 1-2 hours and longer walks of 3-5 minutes progressing as tolerated. A home exercise program was issued and performed (supine ankle pumps, quadriceps and gluteal sets 20 each, heel slides 10), and passive range of motion of the knees/hips was completed; current left knee ROM is 0-80. The patient was instructed to ice the left knee for 20 minutes with a protective barrier, performing skin checks every 5 minutes. Skilled home PT is indicated with a frequency beginning 8/22/25 of 1w1, 3w1, 2w1 to address strength, mobility, transfers, balance, gait safety, and safety awareness and to reduce fall risk; outpatient PT is scheduled to start on 9/9/25, and surgical follow-up with Dr. Narcisse is scheduled for 9/4/25.
 Date of Order 08/22/2025 Orders Physician Face-to-Face Date: 08/04/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left Total Knee 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: PT Eval Notes: Physician Narcisse, Patrick

SN Careplans

SN WK1: 2 (08/22/25-08/23/25)

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; 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 the pt's incision and on post op day 12-14 the nurse or physical therapist will remove the patient's staples and leave OTA., 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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Anterior Left Knee -

PROCEDURES: Discharge from Skilled Nursing- Do DISCHARGE SUMMARY- SN communication note, Medication Review- : Medications reviewed with patient/caregiver., cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: To left knee surgical site- 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.

SN Goals

PATIENT-STATED GOAL: To be able to get around and do everything I was without pain

GOALS
patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive 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
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

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 SN RN	08/22/2025

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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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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

PT Careplans

PT WK1: 1 (08/22/25-08/23/25) ,WK2: 3 (08/24/25-08/30/25) ,WK3: 2 (08/31/25-09/06/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170J1 - Walk 50 ft with 2 Turns, GG0130A1 - Eating, 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, GG0130B1 - Oral Hygiene, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver., cough/deep breathing exercises, home exercise program, therapeutic modalities, equipment training, gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention

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, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 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, Medication Review-

PT Goals

PATIENT-STATED GOAL: I want to be able to walk without my walker

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Medication Review-

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

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

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

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

Signature of Physician:

Date

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

Date
08/22/2025