Home Health Certification and Plan of Care

Order ID: 1150/11593

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
911303732	08/22/2025	From: 08/22/2025 To: 10/20/2025	16083	217058

6. Patient's Name and Address

John Powell
5801 Halwyn Ave,
Baltimore, MD 21212-
410-917-2289

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 06/15/1962 | 9.Sex Male

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

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	08/22/25
I70.0	Atherosclerosis of aorta	08/22/25
I10.	Essential (primary) hypertension	08/22/25
G50.8	Other disorders of trigeminal nerve	08/22/25
M47.12	Other spondylosis with myelopathy cervical region	08/22/25
M50.30	Other cervical disc degeneration unsp cervical region	08/22/25
F31.9	Bipolar disorder unspecified	08/22/25
G89.4	Chronic pain syndrome	08/22/25
N52.8	Other male erectile dysfunction	08/22/25
F14.21	Cocaine dependence in remission	08/22/25
F41.9	Anxiety disorder unspecified	08/22/25
F32.A	Depression unspecified	08/22/25
E78.5	Hyperlipidemia unspecified	08/22/25
K21.9	Gastro-esophageal reflux disease without esophagitis	08/22/25
F12.10	Cannabis abuse uncomplicated	08/22/25
Z86.0100	Personal history of colonic polyps	08/22/25
Z87.442	Personal history of urinary calculi	08/22/25
Z87.891	Personal history of nicotine dependence	08/22/25
Z86.16	Personal history of COVID-19	08/22/25

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

Latuda - Lurasidone Hydrochloride 80 mg,Take 1 tablet by mouth at bedtime
Take 1 tablet by mouth daily at bedtime
Latuda - Lurasidone Hydrochloride 20 mg, Take 1 tablet by mouth at bedtime 20 mg Oral Tab
Take 1 tablet by mouth at bedtime-Add to 80 mg=100 mg daily
Eskalith - Lithium Carbonate 300 mg, Take 1 capsule by mouth twice a day
Take 1 capsule by mouth twice a day
Eskalith - Lithium Carbonate 150 mg, Take 1 capsule by mouth twice a day
Take 1 capsule by mouth twice a day (IN ADDITION TO CURRENT 300 MG TWICE A DAY)
Ritalin - Methylphenidate Hydrochloride 10 mg, Take 1 tablet by mouth three times a day 10 mg Oral Tab
Take 1 tablet by mouth 3 times a day
Lyrica - Pregabalin 25 mg, Take 1 to 2 capsules by mouth twice a day 25 mg Oral Cap
Take 1 to 2 capsules by mouth twice a day as necessary for anxiety
Buspar - Buspirone Hydrochloride 30 mg, Take 1 tablet by mouth twice a day 30 mg Oral Tab
Take 1 tablet by mouth 2 times a day
Keflex - Cephalexin 500 mg, Take 1 capsule by mouth every 12 hours 500 mg Oral Cap
Take 1 capsule by mouth every 12 hours
Lipitor - Atorvastatin Calcium 10 mg, TAKE 1 TABLET by mouth once a day 10 mg Oral Tab
TAKE 1 TABLET DAILY FOR CHOLESTEROL AND HEART PROTECTION
Revatio - Sildenafil Citrate 20 mg, Take 3 or 5 tablets (60 or 100 mg) by mouth as necessary 20 mg Oral Tab
Take 3 or 5 tablets (60 or 100 mg) by mouth 1 hour prior to sexual activity. Do not exceed 1 dose (5 tablets) in 24 hours

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 : 08/08/2025

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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Norvasc - Amlodipine Besylate 5 mg, Take 1 tablet by mouth once a day
Desyrel - Trazodone Hydrochloride 50 mg, TAKE 2 TO 4 TABLETS by mouth at bedtime 50
mg Oral Tab
TAKE 2 TO 4
TABLETS AT
NIGHT AS
NECESSARY
FOR INSOMNIA
Vitamin B1 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 100 mg,Take 1 tablet by mouth once a day
Fish Oil - Cod Liver Oil Take capsules by mouth as necessary
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 4 hours post-surgical pain
Colace - Docusate Sodium 100mg by mouth twice a day 1-2 tab for stool softener
Extra Strength Tylenol - Acetaminophen 500mg by mouth every 6 hours for pain
Motrin - Ibuprofen 600 mg 600mg by mouth every 6 hours pain/inflammation

14. DME and Supplies:

cane, walker

15. Safety Measures:

infectious material management, knee precautions, medication safety, fall precautions, walker precautions, supervision at all times, standard precautions, bathroom safety, anticoagulant precautions, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

low cholesterol, low sodium

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Walker, Up As Tolerated, Complete Bedrest

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: good

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

Homebound status:

After undergoing Right Total Knee Replacement Surgery, 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 63-year-old male with a past medical history significant for osteoarthritis, cervical spondylosis with myelopathy, bipolar disorder, and anxiety, who is currently status post right total knee replacement performed by Dr. Narcisse on 09/04/2025. He resides with his wife in a two-story row home with 12 steps required to enter, with bedroom and bathroom located on the second floor. At the time of assessment, the patient was alert and oriented 3-4, cooperative, and demonstrated appropriate understanding of his current condition and medication regimen. He reported a pain level of 6/10 localized to the operative knee, with associated swelling and bruising noted on physical exam. The surgical bandage over the right knee was intact, with no drainage observed. He denied nausea, vomiting, or abdominal discomfort, and reported passing flatus with his last bowel movement occurring earlier today. Appetite is improving. Lung sounds were clear to auscultation bilaterally with no adventitious sounds. The patient ambulates with a rolling walker for approximately 30 feet on indoor surfaces under supervision, and is able to negotiate 14 steps with rail and cane using a step-to pattern with supervision. Bed mobility, chair transfers, and toilet transfers require supervision. Right knee range of motion was measured at 8-70 degrees. Functional limitations are further evidenced by a Tinetti score of 14/28, indicating a high fall risk and supporting homebound status due to the significant effort required to leave home. A medication reconciliation was completed, with all medications reviewed one by one for indications, actions, and administration. The patient verbalized accurate understanding and independently administers his medications directly from prescription bottles. He was instructed to increase stool softener to 2 tablets twice daily, to maintain hydration to prevent constipation, and to continue incentive spirometer use to promote pulmonary hygiene. Education was provided regarding post-operative care including bandage care (keeping the dressing clean, dry, and intact, avoiding soaking), recognition of concerning signs such as increased swelling, bruising, or drainage, and the importance of contacting his surgeon immediately should these occur. Pain management strategies including NSAID therapy, ice, compression, and elevation were reinforced. The plan of care includes a skilled nursing return visit in 7 days for bandage removal, incision assessment (including swelling, bruising, drainage, and measurement), and photo documentation. The patient will also benefit from skilled home physical therapy to address decreased strength, limited knee range of motion, and reduced functional mobility with the goal of improving independence and promoting a safe return to prior level of function. The patient and his wife verbalized understanding and agreement with the plan of care.
 Date of Order 08/22/2025 Orders Physician Face-to-Face Date: 08/08/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Knee Replacement Surgery 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

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles SN RN

Date

08/22/2025

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SN Careplans

SN WK1: 1 (08/22/25-08/23/25) ,WK2: 1 (08/24/25-08/30/25)

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: 0. No assistance needed - patient is independent or does not have needs in this area

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 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.

Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal blood pressure, swelling of affected area, limited endurance, limited range of motion, limited strength, Pain Interference with Therapy activities, balance deficit, daytime fatigue, difficulty sleeping, Pain Interference with ADLs, Pain Effect on Sleep, loss of appetite, #1 - Non-Observable Surgical Wound - Anterior Right 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, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: To right knee surgical site-Keep dry and clean. 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., coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * 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, * low cholesterol dietary guidelines, 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 optimize mental status with cognition therapy home safety optimize mobility with active and passive range of motion therapeutic exercises diet and fluids to optimize peripheral circulation, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to

SN Goals

PATIENT-STATED GOAL: To get back to normal activities

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 cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to optimize mental status with cognition therapy
* home safety
* optimize mobility with active and passive range of motion therapeutic exercises
* diet and fluids to optimize peripheral circulation
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to promote optimized mobility with strength
* balance
* dexterity
* range-of-motion therapeutic exercises
* promotion of peripheral circulation
* fluid and diet intake to promote healing
* prevent constipation
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

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
* low cholesterol dietary guidelines
* 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

Signature of Physician:	Date
	PAGE 3 of 4
Optional Name/Signature of Nurse/Therapist:	Date
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reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, * how to promote optimized mobility with strength balance dexterity range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing prevent constipation, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence, caregiver performs medical/rehabilitation treatments with adequate competence

* recalls related medication(s) purpose, schedule

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

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

caregiver performs medical/rehabilitation treatments with adequate competence

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: Pain Interference with ADLs, Pain Effect on Sleep, GG0170I1 - Walk 10 Feet, 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, GG0170J1 - Walk 50 ft with 2 Turns, GG0130B1 - Oral Hygiene, 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: Home exercise program : Supine quad sets, short arc quads, hip flexion, hip abduction, straight leg raise. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, Medication Review- : Medications reviewed with patient/caregiver., Stretching to right knee initially 8-70 degrees, physician-ordered wound care: To right 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., equipment training, gait training on uneven surfaces, 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, Oral Hygiene - 06. Independent, Lower Body Dressing - 03. Partial/moderate assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 06. Independent, Car Transfer - 04. Supervision or touching assistance, 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, ROM RIGHT KNEE 0 TO 90 DEGREES

PT Goals

PATIENT-STATED GOAL: To walk independently without pain

GOALS
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

Shower/Bathe Self - 03. Partial/moderate assistance

Car Transfer - 04. Supervision or touching assistance

Walk 150 Feet - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 06. Independent

Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

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

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

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

ROM RIGHT KNEE 0 TO 90 DEGREES

Signature of Physician:	Date
	PAGE 4 of 4
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