

Home Health Certification and Plan of Care				Order ID: 1150/11803	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
341096722		08/26/2025		From: 08/26/2025 To: 10/24/2025	
		4. Medical Record No.		5. Provider No.	
		5824		217058	
6. Patient's Name and Address Folasade Abolarin 9500 Powderhorn Ln, PARKVILLE, MD 21234- 410-258-7853			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 10/24/1955 9.Sex Female			10. Medications: Dose/Frequency/Route (N)ew (C)hanged hydroCHLORothiazide (ESIDRIX/HYDRODIURIL) 25 mg , take 1 Tablet by mouth once a day HTN and edema Ibuprofen (ADVIL/MOTRIN IB) 200 MG , Take 800 mg by mouth once a day As needed for pain Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, take 1 tablet by mouth every 4 hours As needed for pain Extra Strength Tylenol - Acetaminophen 500mg, take 2 tablets by mouth every 6 hours As needed for pain Aspirin 81Mg - Aspirin 81 mg, Take 1 tablet by mouth twice a day Blood thinner Colace - Docusate Sodium 100 mg , Take 1 tablet by mouth twice a day Stool softener		
11. ICD Z47.1		Principal Diagnosis Aftercare following joint replacement surgery		Date 08/26/25	
13. ICD Z96.652 M17.11 I10. M85.80 R73.03 E78.00 E55.9 E66.9 Z68.33 Z86.0102		Other Pertinent Diagnoses Presence of left artificial knee joint Unilateral primary osteoarthritis right knee Essential (primary) hypertension Oth dsrd of bone density and structure unspecified site Prediabetes Pure hypercholesterolemia unspecified Vitamin D deficiency unspecified Obesity unspecified Body mass index [BMI] 33.0-33.9 adult Personal history of hyper		Date 08/26/25 08/26/25 08/26/25 08/26/25 08/26/25 08/26/25 08/26/25 08/26/25 08/26/25 08/26/25	
14. DME and Supplies: bath bench, walker, cane			15. Safety Measures: standard precautions, knee precautions, fall precautions, ambulates with device, walker precautions, bathroom safety, anticoagulant precautions		
16. Nutrition: low sodium			17. Allergies: flu vaccine		
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: 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 patient will be responsible for managing treatment		
Homebound status: After undergoing left 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:		<p class="MsoNoSpacing">The patient is a 69-year-old female with a past medical history of bilateral knee osteoarthritis, hypertension, and a keloid scar from a prior gunshot wound to the right shoulder. She recently underwent a left knee replacement and is currently alert and oriented 4. Vital signs are stable, respiration is even and unlabored, bowel sounds are active, and lungs are clear to auscultation. The patient denies shortness of breath, dizziness, or lightheadedness but does report fatigue. Mild swelling is present around the surgical site. She ambulates using a walker and receives support from her family in her recovery. Education was provided on medication compliance, use of ice, and leg elevation to manage postoperative symptoms. During the visit, the patient presented with significant postoperative pain and edema. She participated in therapeutic exercises, including heel slides, hip abduction and adduction in long sitting, short arc quadriceps exercises, and additional heel slides in a seated position. Training was provided for bed mobility, toilet transfers, and safe ambulation using a walker. The patient was also educated on the proper application of ice and pain management strategies. She is expected to benefit from continued skilled therapy to reduce pain and swelling, improve mobility, and support a safe return to functional independence.</o:p></p> <p class="MsoNoSpacing"><o:p> </o:p></p> <p class="MsoNoSpacing">Date of Order<o:p></o:p></p> <p class="MsoNoSpacing">08/26/2025 Order<o:p></o:p></p> <p class="MsoNoSpacing">Physician Face-to-Face Date: 08/18/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to left 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<o:p></o:p></p> <p class="MsoNoSpacing"> 1 - SOC - SN Notes: PT Eval Notes:<o:p></o:p></p> <p class="MsoNoSpacing">Physician: Narcisse, Patrick</p>			
SN Careplans SN WK1: 1 (08/26/25-08/30/25) ,WK2: 1 (08/31/25-09/06/25) 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, 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 the pt's incision and on post op day 12-14 the nurse or physical therapist will remove the			SN Goals 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 * how to take the patient's blood pressure * record the reading * recalls related medication(s) purpose, schedule patient/caregiver recalls * lifestyle modifications to manage respiratory condition including		
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles SN RN on 08/26/2025				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 : 08/18/2025		
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. PAGE 1 of 3		

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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 ; 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. 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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.			* 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 Goals		
Signature of Physician:			Date		
			PAGE 2 of 3		
Optional Name/Signature of Nurse/Therapist:			Date		
Electronically Signed by Messick, Charles SN RN			08/26/2025		

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PT WK1: 3 (08/26/25-08/30/25) ,WK2: 3 (08/31/25-09/06/25) PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, Pain Interference with ADLs, 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: The medication was reviewed with patient, TKR EXERCISES : Ankle pumps, heel lides, slr, le bd/add, long arc , marching and heel raises --10x2 reps , cough/deep breathing exercises, equipment training, 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, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 06. Independent, 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 - 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	PATIENT-STATED GOAL: The patient wants to be pain free and walk straight GOALS Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance 1 - Step (curb) - 05. Setup or clean-up assistance Chair to Bed to Chair - 06. Independent Toilet Transfer - 06. Independent Lower Body Dressing - 06. Independent Shower/Bathe Self - 06. Independent Car Transfer - 06. Independent Picking Up Object - 05. Setup or clean-up assistance 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 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 Oral Hygiene - 06. Independent Eating - 06. Independent Sit to Stand - 06. Independent Toileting Hygiene - 06. Independent Don/Doff Footwear - 06. Independent 4 Steps - 05. Setup or clean-up assistance 12 Steps - 05. Setup or clean-up assistance
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Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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