Home Health Certification and Plan of Care

Order ID: 1150/11802

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
511025803	08/26/2025	From: 08/26/2025 To: 10/24/2025	16084	217058

6. Patient's Name and Address

Martin Mack
2304 Aquilas Delight,
FALLSTON, MD 21047-
410-967-6459

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 06/01/1955 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	08/26/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	08/26/25
M51.369	Oth intvrt disc degen lum rgn w/o lum bck or lw extrm painOth intvrt disc degen lum rgn w/o lum bck or lw extrm pain	08/26/25
M85.80	Oth disrd of bone density and structure unspecified site	08/26/25
I65.23	Occlusion and stenosis of bilateral carotid arteries	08/26/25
B02.29	Other postherpetic nervous system involvement	08/26/25
H26.9	Unspecified cataract	08/26/25
K21.9	Gastro-esophageal reflux disease without esophagitis	08/26/25
Z85.46	Personal history of malignant neoplasm of prostate	08/26/25
Z85.828	Personal history of other malignant neoplasm of skin	08/26/25
Z86.0100	Personal history of colonic polyps	08/26/25
Z87.891	Personal history of nicotine dependence	08/26/25

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

Lipitor - Atorvastatin Calcium 40 mg,Take 1 tablet by mouth once a day 40 mg
Oral Tab
Take 1
tablet by
mouth
daily for
cholesterol
and heart
protection
Aspirin 81Mg - Aspirin 81 mg, Take 81 mg tablet by mouth once a day Blood thinner
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25 mcg (1,000 unit), Take 1 tablet by mouth once a day Supplement
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
Colace - Docusate Sodium 100mg, take 1 capsule by mouth twice a day stool softener
Zofran - Ondansetron Hydrochloride eq 4 mg base take 1 tablet by mouth every 6 hours As needed for Nausea and Vomiting

14. DME and Supplies:

walker, bath bench

15. Safety Measures:

walker precautions, standard precautions, medication safety, knee precautions, fall precautions, bathroom safety, anticoagulant precautions, ambulates with device, ambulates with assistance

16. Nutrition:

regular

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Cane, Walker

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
another facility/provider 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 70-year-old male with a past medical history significant for bilateral carotid artery stenosis and osteoarthritis of the right knee, who is now status post right total knee replacement (TKR). He is alert and oriented x4. The patient reported experiencing vomiting after taking oxycodone on two occasions; a message was left for Dr. Narcisee to report this adverse reaction and request an alternative analgesic, and the patient confirmed that he also notified the nurse and is awaiting the surgeon's response. His vital signs were stable during assessment, respirations were even and unlabored, bowel sounds were active, and lung fields were clear to auscultation bilaterally. He denied shortness of breath but endorsed occasional dizziness, lightheadedness, and fatigue. Mild postoperative swelling was observed around the surgical site. The patient ambulates with a rolling walker and completed therapeutic exercises during this session, including hamstring stretches, heel slides, and assisted straight leg raises in a reclined position; joint mobilization exercises and long arc quadriceps in sitting; and marching and heel raises in standing, with each exercise performed for two sets of ten repetitions. He was also trained in heel-to-toe gait sequencing with a rolling walker and instructed on the use of ice for pain and edema control. Education was provided regarding medication compliance, proper use of ice and limb elevation, and safe ambulation techniques. His family is actively involved in his care and supportive of his recovery. The patient continues to demonstrate severe postoperative pain with associated edema but is making progress with mobility training and exercises. Ongoing skilled physical therapy is recommended to improve strength, range of motion, balance, gait quality, and pain management to promote safe mobility and optimal recovery. Coordination with the surgeon regarding medication management is ongoing, and the plan of care includes continued skilled nursing and therapy visits to monitor progress, reinforce education, and provide interventions as indicated.
 Date of Order 08/26/2025 Orders Physician Face-to-Face Date: 08/05/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to 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
 <span

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 : 08/05/2025

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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style="font-size: 14px;">1 - SOC - SN Notes: PT Eval Notes: Physician Narcisse, Patrick

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: 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, nausea/vomiting, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, loss of appetite, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Knee -

PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: Right knee surgical site: Remove Aquacell dressing on the 7th day post op and LOTA; otherwise, cover with a gauze dressing if drainage occurs.

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, * low-fat diet lifestyle modifications to manage esophageal condition, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

SN Goals

PATIENT-STATED GOAL: To walk without pain.;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
* low-fat diet
* lifestyle modifications to manage esophageal condition
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles SN RN

Date

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: 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: Medication Review: The medication was reviewed with the patient , TKR Exercises H E P: Ankle pumps , heel slides, le abd/add, slr, long arc, marching and heel raises --10x2 reps , TKR Exercises H E P: Ankle pumps , heel slides, le abd/add, slr, long arc, marching and heel raises --10x2 reps , 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 - 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 - 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: To walk straight and pain free

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

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

Chair to Bed to Chair - 06. Independent

Car 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

Sit to Stand - 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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

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

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