

Home Health Certification and Plan of Care				Order ID: 1150/13584	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
99291580		10/24/2025		From: 10/24/2025 To: 12/22/2025	
				4. Medical Record No.	
				9402	
				5. Provider No.	
				217058	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
John Kellogg 11 Windmill Chase, Sparks Glencoe, MD 21152- 607-220-8850			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
09/10/1958			Male		
11. ICD			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
Z47.1			Aspirin - Aspirin 81mg by mouth twice a day Blood thinner		
Principal Diagnosis			Vitamin C - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol:		
Aftercare following joint replacement surgery			Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000mg by		
Date			mouth in the morning Supplement		
10/24/25			Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth once a day		
13. ICD			Taken ever 4 hrs as needed for pain		
Z96.642			B 12 - Ascorbic Acid: Biotin: Cyanocobalamin: Dexpanthenol: Ergocalciferol:		
Other Pertinent Diagnoses			Folic Acid: Niacinamide: Pyridoxine Hydrochloride: Riboflav 1mg by mouth		
Z96.642			once a day Supplement		
110.			Losartan Potassium - Losartan Potassium 100 mg 100mg by mouth once a		
Essential (primary) hypertension			day Htn management		
E78.5			Crestor - Rosuvastatin Calcium 10 mg, Take 1 tablet by mouth once a day to		
Hyperlipidemia unspecified			prevent heart		
M16.0			attack and stroke,.		
Bilateral primary osteoarthritis of hip			Pt not currently taking		
Z85.828			Norvasc - Amlodipine Besylate eq 5 mg base 5 mg , Take 1 tablet by mouth		
Personal history of other malignant neoplasm of skin			once a day Taken at night for htn management		
Z86.711					
Personal history of pulmonary embolism					
14. DME and Supplies:			15. Safety Measures:		
cane, wheelchair, walker			bathroom safety, , , ambulates with device, infectious material management,		
			walker precautions, , hip precautions, ,		
16. Nutrition:			17. Allergies:		
Z. NO PHYSICIAN-ORDERED DIET			cipro duricef pcn amlodipine besylate		
18.A. Functional Limitations			18.B. Activities Permitted		
Ambulation			Wheelchair, Walker, Cane, Up As Tolerated		
19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No					
20. Prognosis: good					
22. A Rehabilitation Potential:			22.B.Discharge Plans		
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.			patient will be responsible for managing treatment		
Homebound status: After undergoing Total Left Hip 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: <div>The patient is a 67-year-old male who is alert and oriented 4, currently receiving home health services following discharge after a total left hip replacement surgery. His past medical history is significant for hypertension, bilateral primary osteoarthritis of the hips, and hyperlipidemia. At the time of <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient rated his pain as 3/10, having taken oxycodone earlier that morning for pain management. Vital signs were within normal limits, and the patient reported his last bowel movement occurred today. The surgical incision was covered with an intact dressing, showing minimal redness and slight inflammation, with no drainage or other signs of infection noted. The patient demonstrates good comprehension of his medication regimen, including purpose, dosage, and administration schedule, and reports full compliance. He utilizes his prescribed assistive device appropriately for ambulation and activities of daily living. A Timed Up and Go (TUG) test was completed in 39 seconds, indicating a high fall risk. The patient reported that he is using Miralax for bowel regulation and denied any current issues with bowel movements. He receives occasional assistance from a friend and coworker who provides support with daily care needs. Comprehensive education was provided on wound care management, fall prevention strategies, and signs and symptoms of infection. The patient verbalized understanding of all teaching points. Per discharge instructions, the Aquacel dressing is to remain in place and be removed within seven days. A follow-up home visit is scheduled for wound re<mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> and dressing removal at that time. The plan of care includes continued skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> to monitor wound healing progress, assess pain control, reinforce education, and ensure ongoing safety and adherence to postoperative recovery guidelines.</div><div> </div><div> </div><div>Date of Order</div><div>10/24/2025</div><div>Orders</div><div>Physician Face-to-Face Date: 10/09/2025</div><div>Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Total Left Hip Replacement Surgery</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div> </div><div> </div><div>1 - SOC - SN Notes: soc</div><div>PT Eval Notes: eval</div><div> </div><div>Physician</div><div>Narcisse, Patrick</div></div>					
SN Careplans			SN Goals		
SN WK1: 1 (10/24/25-10/25/25) ,WK2: 1 (10/26/25-11/01/25)			PATIENT-STATED GOAL: "To walk normally"		
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			GOALS		
CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance			patient/caregiver recalls		
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications			* how to achieve wound healing including cleaning and dressing wound		
STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if			* position changes		
			* skin care		
			* diet modification		
			* record wound measurements		
			* recalls related medication(s) purpose, schedule		
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 10/24/2025					
24. Physician's Name and Address			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.		
Patrick Narcisse			F2F date : 10/09/2025		
2391 Greenspring Dr					
Timonium , MD 21093					
PHONE: 410-847-3000 FAX: NPI: 1508397092					
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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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:Living Will PROBLEMS IDENTIFIED ON ASSESSMENT: meal preparation, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M1400 - Dyspnea, limited range of motion, limited strength, limited endurance, Pain Interference with Therapy activities, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Anterior Left Hip - PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , Discharge Summary- Complete Discharge Summary SN communication note. , cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: To left hip 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., teach/coordinate/arrange medication packaging and/or administration 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, * how to manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, 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 administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence			patient/caregiver recalls * how to manage inflammatory process * optimize mobility with active and passive range of motion exercises * fluid and diet intake to promote healing * prevent constipation * home safety * 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 patient is adequately supervised meal preparation is available to patient for all meals caregiver administers and/or packages medications appropriately caregiver performs medical/rehabilitation treatments with adequate competence			
PT Careplans			PT Goals			
PT WK1: 1 (10/24/25-10/25/25) ,WK2: 3 (10/26/25-11/01/25) ,WK3: 2 (11/02/25-11/08/25)			PATIENT-STATED GOAL: To improve walking			
PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170G1 - Car Transfer, 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, GG0170I1 - Walk 10 Feet, GG0130B1 - Oral Hygiene, 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			GOALS Chair to Bed to Chair - 06. Independent			
PROCEDURES: Therapeutic exercise , Dynamic standing balance , Medication Review- Medications reviewed with patient/caregiver., gait training on uneven surfaces, gait training/stair training, transfers training			Toilet Transfer - 06. Independent			
TEACH PATIENT/CAREGIVER: Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Sit to Stand			Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance			
			1 - Step (curb) - 05. Setup or clean-up assistance			
			Car Transfer - 06. Independent			
			Shower/Bathe Self - 03. Partial/moderate assistance			
			Medication Review- Patient/caregiver recalls related purpose and schedule of medications.			
Signature of Physician:			Date			
			PAGE 2 of 3			
Optional Name/Signature of Nurse/Therapist:			Date			
Electronically Signed by Messick, Charles RN			10/24/2025			

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- 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, Medication Review- Patient/caregiver, related purpose and schedule of medications.		Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Eating - 06. Independent Walk 10 Feet - 05. Setup or clean-up assistance Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance Sit to Stand - 06. Independent 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 Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent		

Signature of Physician:	Date
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