Home Health Certification and Plan of Care

Order ID: 1150/14858

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
15124630	12/11/2025	From: 12/11/2025 To: 02/08/2026	19756	217058

6. Patient's Name and Address

Barry Wright
5916 Frankford Ave.,
BALTIMORE, MD 21206-
410-325-1285

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 09/21/1957 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	12/11/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	12/11/25
M17.11	Unilateral primary osteoarthritis right knee	12/11/25
I10.	Essential (primary) hypertension	12/11/25
I05.0	Rheumatic mitral stenosis	12/11/25
E78.00	Pure hypercholesterolemia unspecified	12/11/25
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	12/11/25
E53.8	Deficiency of other specified B group vitamins	12/11/25
E04.9	Nontoxic goiter unspecified	12/11/25
H40.9	Unspecified glaucoma	12/11/25
E55.9	Vitamin D deficiency unspecified	12/11/25
E21.0	Primary hyperparathyroidism	12/11/25
Z85.46	Personal history of malignant neoplasm of prostate	12/11/25

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

Hygroton - Chlorthalidone 25 mg, Take 2 tablets by mouth once a day
Flomax - Tamsulosin Hydrochloride 0.4 mg, Take 1 capsule by mouth at bedtime Take 1
capsule by
mouth daily
at bedtime
Mobic - Meloxicam 15 mg, Take 1 tablet by mouth once a day
Cozaar - Losartan Potassium 25 mg, Take 1 tablet by mouth once a day
Tylenol - Acetaminophen 500mg by mouth every 6 hours Take two tabs of 500mg Tylenol every 6 hours as needed for pain.
Motrin - Ibuprofen 100 mg 2 tabs every 6 hours as needed for pain by mouth every 6 hours Take two tabs of 100 mg Motrin every 6 hours as needed for pain. Alternate with Tylenol.
Asa - Aspirin 81mg by mouth twice a day Take 1 tab of 81mg Aspirin twice daily for cardiac prevention methods
Colace - Docusate Sodium 1 tab by mouth twice a day Take one tab of Colace twice daily for stool softening
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth every 6 hours Take one tab every 6 hours as needed for pain

14. DME and Supplies:

rolling walker, hand held shower, walker, wound care supplies, cane, 4 wheeled walker, elevated toilet seat

15. Safety Measures:

walker precautions, smoke detectors , restricted ROM, medication safety, fall precautions, bleeding precautions, ambulates with device, supervision at all times, emergency phone # clearly displayed, ambulates with assistance, standard precautions, knee precautions, bathroom safety, anticoagulant precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

amlodipine besylate lipitor

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Up As Tolerated, Walker, Exercises Prescribed, Transfer bed/Chair

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: good

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 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 68-year-old male, postoperative day one following a left total knee arthroplasty. Upon RN arrival, he was resting comfortably on the couch in the basement with his left leg elevated and an ice machine in place to manage pain and edema. He lives in a townhome with his wife, who is his primary caregiver, and has access to a bathroom on the basement level. He is able to navigate stairs and currently ambulates with a four-wheeled rolling walker with one-person assist. Pain was reported as 4/10 and is well controlled with oxycodone and acetaminophen. His appetite is good, and his last bowel movement was on 12/9; education was provided on increasing fluid and protein intake to support wound healing. All medications were present in the home, and medication purpose and side effects were reviewed, with the patient demonstrating good understanding. Past medical history is significant for hypertension, hyperlipidemia, hyperparathyroidism, hypercalcemia, benign elevated PSA, left knee osteoarthritis, renal calculus, vitamin B12 and D deficiencies, cataracts, and glaucoma suspect; there is no history of diabetes or eye trauma. Noted drug allergies include amlodipine (edema), atorvastatin (myalgias/weakness), and pravastatin (questionable rash). Physical therapy evaluation was completed earlier in the day, with plans to return tomorrow. The patient presents with decreased left lower extremity strength and range of motion, including knee extension limited to -5 degrees from neutral and flexion to 85 degrees, requiring contact guard assist for transfers and short-distance ambulation. He was instructed in an initial home exercise program focusing on knee flexion and extension and would benefit from continued skilled PT to improve strength, ROM, and safety with mobility to return to prior level of function. Follow-up with the surgeon, Dr. Narcisse, is scheduled for 12/23.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 12/11/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 11/19/2025
 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval Notes:<o:p></o:p> Physician: Narcisse, Patrick

SN Careplans

SN WK1: 1 (12/11/25-12/13/25) ,WK2: 1 (12/14/25-12/20/25)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 6. Reported or observed history of difficulty complying with any medical

SN Goals

PATIENT-STATED GOAL: Patient wants to be able to walk around the block again

GOALS
patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 12/11/2025

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 : 11/19/2025

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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instructions (for example, medications, diet, exercise) in the past 3 months

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/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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, erectile dysfunction, muscle weakness, limited range of motion, limited strength, swelling of affected area, poor muscle tone, limited endurance, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Other - Left Knee - 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.

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , Discharge Summary- Complete Discharge Summary SN communication note. , cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: 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 PATIENT/CAREGIVER: * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, caregiver performs medical/rehabilitation treatments with adequate competence * recalls related medication(s) purpose, schedule

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 2 (12/11/25-12/13/25) ,WK2: 3 (12/14/25-12/20/25) ,WK3: 1 (12/21/25-12/27/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, 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, equipment training, gait training on uneven surfaces, gait training/stair training, transfers training, therapeutic exercises

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 - 05. Setup or clean-up assistance, Upper Body Dressing -

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

GOALS
Lower Body Dressing - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Car Transfer - 04. Supervision or touching assistance

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

1 - Step (curb) - 04. Supervision or touching assistance

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Eating - 06. Independent

Sit to Stand - 04. Supervision or touching assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

12/11/2025

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05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 05. Setup or clean-up assistance, Car Transfer - 04. Supervision or touching assistance, 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

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

Toilet Transfer - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 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

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

Upper Body Dressing - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/11/2025