Home Health Certification and Plan of Care

Order ID: 1150/14761

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
641088609	12/10/2025	From: 12/10/2025 To: 02/07/2026	13965	217058

6. Patient's Name and Address

Carol Roberts
10416 Fernwood Rd.,
COCKEYSVILLE, MD 21030-
410-812-4449

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 12/29/1935 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	12/10/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	12/10/25
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	12/10/25
N18.31	Chronic kidney disease stage 3a	12/10/25
E78.5	Hyperlipidemia unspecified	12/10/25
G25.81	Restless legs syndrome	12/10/25
F41.1	Generalized anxiety disorder	12/10/25
I70.0	Atherosclerosis of aorta	12/10/25
G31.84	Mild cognitive impairment of uncertain or unknown etiology	12/10/25
H90.3	Sensorineural hearing loss bilateral	12/10/25
G47.9	Sleep disorder unspecified	12/10/25
R73.03	Prediabetes	12/10/25
Z79.82	Long term (current) use of aspirin	12/10/25
Z79.02	Long term (current) use of antithrombotics/antiplatelets	12/10/25
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	12/10/25
Z97.4	Presence of external hearing-aid	12/10/25

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

Plavix - Clopidogrel Bisulfate 75 mg , Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for 90 days
Lipitor - Atorvastatin Calcium 80 mg , Take 1 tablet by mouth once a day Take 1 tablet by mouth daily For cholesterol and heart protection.
Aspirin (ECOTRIN LOW STRENGTH) 81 mg , Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for 30 days
Ultram - Tramadol Hydrochloride 50 mg, Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day after meals as needed for severe pain (shoulder)
Buspar - Buspirone Hydrochloride 5 mg , Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day
Requip - Ropinirole Hydrochloride 0.25 mg , Take 2 tablets by mouth once a day Take 2 tablets by mouth daily at bedtime
Norvasc - Amlodipine Besylate 5 mg , Take 1 tablet by mouth once a day Take 1 tablet by mouth daily
Remeron - Mirtazapine 45 mg , Take 1 tablet by mouth once a day Take 1 tablet by mouth daily at bedtime
Vitamin C - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 250mg by mouth once a day Take one chewable tab daily for supplement
Vitamin D-3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50 MCG by mouth once a day Take one tab daily for spllement
Lisinopril - Lisinopril 40 mg 40mg by mouth once a day Take one tab daily for blood pressure
Extra Strength Tylenol - Acetaminophen 500mg by mouth every 6 hours Take one tab every 6 hours as needed for pain level >6/10

14. DME and Supplies:

wound care supplies, grab bars, walker, bath bench, hand held shower, rolling walker, wheelchair

15. Safety Measures:

activity supervision, bathroom safety, smoke detectors , restricted ROM, medication safety, fall precautions, bleeding precautions, ambulates with device, transfer with assist, supervision at all times, standard precautions, knee precautions, anticoagulant precautions, ambulates with assistance

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Hearing, Ambulation, Endurance, Bowel/Bladder Incontinence, Speech

18.B. Activities Permitted

Transfer bed/Chair, Wheelchair, Crutches, None of the above, Cane, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: good

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 12/10/2025

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 : 11/18/2025

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.

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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
family/caregiver 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 an 89-year-old female, post-operative day two following a left total knee replacement, with a past medical history significant for hyperlipidemia, prediabetes, hypertension, restless leg syndrome, and stage 3 chronic kidney disease. She is currently staying with her daughter and son-in-law until she is stable enough to return home in Foresthill, Maryland. Prior to surgery, she was mostly independent at home using a walker. She now requires caregiver assistance for all indoor ambulation due to bilateral lower extremity weakness, decreased coordination, altered gait mechanics, and easy fatigability. Pain is mild to moderate (5/10) and managed with Tylenol, tramadol, knee elevation, and ice application. The patient takes all medications as prescribed, and medication education including side effects and constipation relief measures was provided. She was also educated on fall prevention and safe use of her rolling walker. Bed mobility and transfers are currently slow and effortful but are expected to progress with skilled physical therapy. Ambulation is limited to short distances with assistance, with the goal of achieving safe household gait prior to transitioning to outpatient therapy. Mild swelling is noted at the surgical site. The patient is alert, motivated, and eager to return to her home once safe. She has a post-operative follow-up appointment scheduled with her surgeon on 12/23. Skilled PT is required to restore safe mobility, improve strength, and prevent falls.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 12/10/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 11/18/2025
 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 (12/10/25-12/13/25) ,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: 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/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: M1720 - Anxiety, M1700 - Cognition, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M2102f - Patient Supervision, M2102c - Med Admin, M1400 - Dyspnea, constipation, limited endurance, limited strength, limited range of motion,

SN Goals

PATIENT-STATED GOAL: Patient wants to return to her home
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 keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* 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

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
12/10/2025

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swelling of affected area, muscle weakness, balance deficit, impaired speech, B0200 - Hearing Deficit, difficulty sleeping, weak hand grips, Pain Interference with ADLs, loss of appetite, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Other - left knee - non removeable aquacel dressing

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, 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/coordinate/arrange medication packaging and/or administration: Review meds at each visit

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, * 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 keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, related medication(s) purpose, schedule, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (12/10/25-12/13/25) ,WK2: 3 (12/14/25-12/20/25) ,WK3: 2 (12/21/25-12/27/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, 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, 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, GG0130B1 - Oral Hygiene

PROCEDURES: HEP: 10 reps x 1- 2 sets as tolerated: Supine Hip Abd/add, quad sets, SLR, Heel slides, SAQs, Ankle Pumps, Glut Sets, Seated LAQs, Seated Heel Slides with active Assist of opposite foot to push back into flexion. Stair Stretch 5 reps hold 20 secs each. Then progress to exhange lying exercises with Standing exercises: March in place, SLR, partial squats , Hip abd, Medication Review: Patient verbalized understanding of current prescriptions, dosages, and schedule. No reported issues with adherence, side effects, or confusion at this time. , B LE strengthening, work simplification/energy conservation, 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 - 06. Independent, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, 1 - Step (curb) - 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 - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT Goals

PATIENT-STATED GOAL: To go to outpatient

GOALS
Chair to Bed to Chair - 06. Independent

Toilet 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

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

1 - Step (curb) - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/10/2025