Home Health Certification and Plan of Care

Order ID: 1150/16458

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
9PC9Q42WJ17	02/20/2026	From: 02/20/2026 To: 04/20/2026	5239	217058

6. Patient's Name and Address

Leonard Sligh
2043 Sue Ave,
ESSEX, MD 21221-
443-632-4142

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 08/21/1952 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	02/20/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	02/20/26
M15.0	Primary generalized (osteo)arthritis	02/20/26
I10.	Essential (primary) hypertension	02/20/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	02/20/26
I70.0	Atherosclerosis of aorta	02/20/26
M47.812	Spondylosis w/o myelopathy or radiculopathy cervical region	02/20/26
F41.1	Generalized anxiety disorder	02/20/26
E78.00	Pure hypercholesterolemia unspecified	02/20/26
M05.9	Rheumatoid arthritis with rheumatoid factor unspecified	02/20/26
N52.8	Other male erectile dysfunction	02/20/26
D69.3	Immune thrombocytopenic purpura	02/20/26
D69.6	Thrombocytopenia unspecified	02/20/26
F33.9	Major depressive disorder recurrent unspecified	02/20/26
H04.123	Dry eye syndrome of bilateral lacrimal glands	02/20/26
R73.03	Prediabetes	02/20/26
K21.9	Gastro-esophageal reflux disease without esophagitis	02/20/26
E66.01	Morbid (severe) obesity due to excess calories	02/20/26
Z68.41	Body mass index [BMI] 40.0-44.9 adult	02/20/26
Z79.82	Long term (current) use of aspirin	02/20/26
Z96.642	Presence of left artificial hip joint	02/20/26
Z99.89	Dependence on other enabling machines and devices	02/20/26
Z86.0100	Personal history of colonic polyps	02/20/26
Z87.891	Personal history of nicotine dependence	02/20/26

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

Aspirin (ECOTRIN LOW STRENGTH) Take 81 mg by mouth once a day
Lactobacillus acidophilus (PROBIOTIC ORAL) take 1 tablet by mouth once a day
Voltaren - Diclofenac Sodium 1 % Top Gel, Apply 4 g topical four times a day for 90 days.
Wellbutrin Xl - Bupropion Hydrochloride 300 mg, Take 1 tablet by mouth once a day
Celexa - Citalopram Hydrobromide 20 mg, Take 1 and one-half tablets by mouth once a day
Protonix - Pantoprazole Sodium 20 mg, Take 1 tablet by mouth as necessary daily 30 to 60 minutes prior to a meal.
Norvasc - Amlodipine Besylate 10 mg, Take 1 tablet by mouth once a day (Patient taking differently: Take 5 mg by mouth daily).
Singulair - Montelukast Sodium 10 mg , Take 1 tablet by mouth in the evening
Neurontin - Gabapentin 100 MG, take 1 capsule by mouth twice a day
Cozaar - Losartan Potassium 100 MG, take 1 tablet by mouth once a day
Lasix - Furosemide 20 mg Oral Tab, take 1 tablet by mouth in the morning
Lipitor - Atorvastatin Calcium 40 mg, take 1 tablet by mouth at bedtime
Hytrin - Terazosin Hydrochloride 2 mg Oral Cap, Take 1 capsule by mouth twice a day
Colace - Docusate Sodium 100 MG, take 1 capsule by mouth twice a day
Tylenol - Acetaminophen 500 mg, Take 1 tablet by mouth every 6 hours
Proventil - Albuterol 90 mcg/actuation Inhl HFAA, Inhale 1 puff inhalant every 4 hours (Rescue inhaler)
Cholecalciferol, Vitamin D3, (VITAMIN D3) 50 mcg (2,000 unit) Oral Tab Take 2,000 Units by mouth once a day
Motrin - Ibuprofen 200 mg,take 4 tablets by mouth once a day
Roxicodone - Oxycodone Hydrochloride 5 mg Oral Tab, Take 1 tablet by mouth every 4 hours as needed for pain.
Etanercept (ENBREL SURECLICK) 50 mg/mL (1 mL),Inject 1 pen (50mg) subcutaneous as necessary Inject 1 pen (50mg) subcutaneously once every 10 days for rheumatoid arthritis.

14. DME and Supplies:

cane, 4 wheeled walker, grab bars, walker, rolling walker, hand held shower, bath bench

15. Safety Measures:

ambulates with device, , , , restricted ROM, smoke detectors , transfer with assist, supervision at all times, emergency phone # clearly displayed, ambulates with assistance, , knee precautions, hand rails, bathroom safety, , activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

beta blockers oxycodone

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Walker, Exercises Prescribed, 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: Yes

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

family/caregiver will be responsible for managing treatment
another facility/provider will be responsible for managing treatment

Homebound status:

After undergoing Left Total Knee Replacement, 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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/20/2026

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 : 01/27/2026

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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Clinical Condition Requiring Homecare:

The patient is a 73-year-old male with a history of chronic, progressively worsening left medial knee pain secondary to a prior injury sustained during a pier collapse. Conservative management, including hyaluronic acid (Euflexxa) injections, failed to provide significant relief. Approximately one week prior to surgery, he reported severe pain necessitating the use of a cane and knee brace for ambulation, with exacerbation during movement and when turning in bed. The patient subsequently underwent a left total knee replacement and is now being seen postoperatively with expected pain and edema. At the time of assessment, pain is reported as well controlled. He is alert and oriented, ambulating with a walker and one-person assistance. All prescribed medications are present in the home. He is designated as Full Code, with a MOLST form on file. The patient resides in a single-family, single-level home with his wife and two dogs. The home is free of interior steps, and he utilizes a ramp located off the garage for entry and exit, originally constructed for a previously disabled pet. Durable medical equipment available in the home includes a walker, cane, shower bench in a walk-in shower, and an ice machine for cryotherapy. A therapy evaluation was completed today. During the visit, the patient was positioned in a reclined chair and participated in therapeutic exercises to address postoperative weakness, range of motion, and circulation. Exercises included ankle pumps, heel slides, lower extremity abduction and adduction, assisted straight leg raises, long arc quadriceps exercises, marching in place, and heel raises, all performed for 10 repetitions x 2 sets. He tolerated the session without acute distress. Education was provided regarding proper and safe use of the walker to reduce fall risk, reinforcement of total knee precautions, and the importance of maintaining a clear pathway free from pets to prevent accidental injury or contamination of the surgical site. He was instructed on appropriate ice application to manage postoperative edema and pain, including recommended duration and frequency. Ongoing emphasis was placed on mobility, circulation exercises to prevent complications such as deep vein thrombosis, and adherence to prescribed medications. The patient is scheduled to begin outpatient physical therapy in two weeks. Skilled nursing will continue to monitor postoperative recovery, pain control, wound status, and functional mobility, with a planned second nursing visit for discharge if stable and progressing appropriately. The overall goal of care is to promote safe recovery, restore functional independence, prevent postoperative complications, and transition successfully to outpatient rehabilitation services.
 Date of Order 02/20/2026 Orders Physician Face-to-Face Date: 01/27/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left Total Knee Replacement Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc PT Eval Notes: eval
 Physician Narcisse, Patrick

SN Careplans

SN WK1: 1 (02/20/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26)

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: D0160 - Depression, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, dependent edema, limited range of motion, muscle weakness, swelling of affected area, limited endurance, limited strength, Pain Interference with ADLs, daytime fatigue, balance deficit, difficulty sleeping, lethargy, Pain Effect on Sleep, bruising/discoloration, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Other - Left Knee - Left TKA with surgical dressing intact. No s/s of infection noted.

SN Goals

PATIENT-STATED GOAL: Patient states he wants to get back to work as he is a full time contractor and misses working.

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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* 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 medicatio

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

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/20/2026

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PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Left Knee - Left TKA with surgical dressing intact. No s/s of infection noted.: 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., incentive spirometer, 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 medicatio, * 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 1 (02/20/26-02/21/26) ,WK2: 3 (02/22/26-02/28/26) ,WK3: 2 (03/01/26-03/07/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Effect on Sleep, GG0170I1 - Walk 10 Feet, 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: cough/deep breathing exercises, incentive spirometer, 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, 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To walk straight

GOALS
Chair to Bed to Chair - 06. Independent

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

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

Sit to Stand - 06. Independent

Car Transfer - 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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/20/2026