Home Health Certification and Plan of Care

Order ID: 1150/16477

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
19130746	02/20/2026	From: 02/20/2026 To: 04/20/2026	16081	217058

6. Patient's Name and Address

Deborah Haegerich
232 Glen Rd,
PASADENA, MD 21122-
410-279-9088

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 02/07/1951 **9.Sex** Female

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

13. ICD	Other Pertinent Diagnoses	Date
Z96.653	Presence of artificial knee joint bilateral	02/20/26
I10.	Essential (primary) hypertension	02/20/26
E78.00	Pure hypercholesterolemia unspecified	02/20/26
N20.0	Calculus of kidney	02/20/26
F32.A	Depression unspecified	02/20/26
I25.2	Old myocardial infarction	02/20/26
E55.9	Vitamin D deficiency unspecified	02/20/26
K21.9	Gastro-esophageal reflux disease without esophagitis	02/20/26
E66.9	Obesity unspecified	02/20/26
Z68.31	Body mass index [BMI] 31.0-31.9 adult	02/20/26
Z85.3	Personal history of malignant neoplasm of breast	02/20/26
Z79.82	Long term (current) use of aspirin	02/20/26

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

Prinivil - Lisinopril 10 mg, Take 1 tablet by mouth once a day
Tenormin - Atenolol 25 mg, Take 2 tablets by mouth in the morning Take 2 tablets by mouth every morning for hypertension
Norvasc - Amlodipine Besylate 5 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily (PLEASE SCHEDULE A FOLLOW UP VISIT WITH US SOON).
Lipitor - Atorvastatin Calcium 40 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for cholesterol and heart protection
Protonix - Pantoprazole Sodium 40 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily , use sparingly
Lexapro - Escitalopram Oxalate 20 mg, Take 1 tablet by mouth once a day
Timoptic - Timolol Maleate 0.5 % Opht Drop Instill 1 Drop left eye once a day Instill 1 Drop in left eye daily For 1 week
Ibuprofen - Ibuprofen 600 mg 1 tab by mouth every 6 hours For pain
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg 1-2 tabs by mouth every 4 hours For pain
Aspirin 81Mg - Aspirin 1 tab by mouth once a day Clot prevention
Extra Strength Tylenol - Acetaminophen 500 mg, Take 2 tablet (1,000 mg total) by mouth as necessary For pain
Probiotic Fiber Gummies 2 gummies by mouth once a day Supplement
Fiber Therapy 1 cap by mouth once a day Supplement
Magnesium Oxide - Simethicone 400 mg by mouth once a day Supplement
Docusate Sodium - Docusate Sodium 100 mg I tab by mouth twice a day Constipation
Vitamin B Complex 1 tab by mouth once a day Supplement
Vitamin C - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tab by mouth once a day Supplement

14. DME and Supplies:

rolling walker

15. Safety Measures:

walker precautions, transfer with assist, knee precautions, fall precautions, bathroom safety, ambulates with device, ambulates with assistance, activity supervision,

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation,

18.B. Activities Permitted

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: 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

patient 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.

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 : 02/02/2026

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 75-year-old female with a past medical history of bilateral knee osteoarthritis who underwent right total knee replacement on 2/19/26 and returned home the same day with assistance from her spouse and family. Skilled nursing is providing postoperative monitoring and follow-up care. She is alert and oriented 3, resting comfortably, and denies chest pain or shortness of breath. She reports radiating pain at the surgical site rated 5/10, which is well controlled with prescribed medication. A non-removable dressing to the right knee is clean, dry, and intact, with removal scheduled for 2/27/26. She uses a cold therapy unit as prescribed and wears TED stockings; no bilateral lower extremity swelling is noted. She reports a bowel movement two days ago without complications and remains on a bowel regimen, with education provided regarding stool softener use. Medications were reviewed with no discrepancies or refill needs. She is scheduled for surgical follow-up on 3/5/26 and to begin outpatient physical therapy on 3/6/26. Physical therapy evaluation indicates decreased endurance, strength, range of motion (right knee ROM 0-78 degrees), balance, and functional mobility, resulting in impaired transfers, unsteady gait, difficulty negotiating stairs, and increased fall risk. She requires standby to minimal assistance for transfers and ambulation with a walker and minimal to moderate assistance for bed mobility. She was instructed in a home exercise program, including ankle pumps, quadriceps and gluteal sets, and heel slides, as well as safe transfer techniques, walker use, edema management, daily ambulation, pain management, and signs and symptoms of infection. The patient demonstrated understanding through teach-back. Due to decreased mobility and increased fall risk, she is considered homebound, requiring assistance and an assistive device to leave the home safely. She will receive home physical therapy per the established plan of care to improve strength, mobility, balance, and safety, with the goal of restoring independence and preventing further functional decline.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 02/20/2026
 Physician Face-to-Face Date: 02/02/2026
 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat 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<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval Notes: <span style="font-size: 10.5pt; background-image: initial; background-position: initial; background-size: initial; background-repeat: initial; background-attachment: initial; background-origin: initial; background-clip: initial;"><o:p></o:p> 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: 1. Non-agency caregiver(s) currently 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, red/tender pressure points

PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: To left knee 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 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,

SN Goals

PATIENT-STATED GOAL: to walk without pain

GOALS
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 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

meal preparation is available to patient for all meals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

02/20/2026

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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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

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 Interference with Therapy activities, Pain Effect on Sleep, GG0170P1 - Picking Up Object, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, GG0170F1 - Toilet Transfer, 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

PROCEDURES: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex Standing-Mini squat, heel/toe raise, hip flex, leg curls., therapeutic modalities: Apply ice to R knee x 20 minutes with necessary barrier and skin assessments q 5 minutes., 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 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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, 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: I want to get back to being independent

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 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 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

Car Transfer - 06. Independent

12 Steps - 04. Supervision or touching assistance

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

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

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

Oral Hygiene - 06. Independent

Eating - 06. Independent

Sit to Stand - 06. Independent

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

4 Steps - 04. Supervision or touching assistance

Picking Up Object - 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	02/20/2026