

Home Health Certification and Plan of Care				Order ID: 1150/17071	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
14292370		03/12/2026		From: 03/12/2026 To: 05/10/2026	
				4. Medical Record No.	
				22801	
				5. Provider No.	
				217058	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Deborah Linsensmeyer			HomeCentris Healthcare LLC		
3815 Willoughby Beach Rd,			10 Crossroads Drive, Suite 102		
EDGEWOOD, MD 21040-			Owings Mills, MD 21117-8284		
443-865-5845			410-321-8448		
			1487113239		
8. DOB			9. Sex		
01/16/1955			Female		
11. ICD			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
Z47.1			MELOXICAM 1 tablet Oral daily as needed for pain As needed for pain		
Principal Diagnosis			AMLODIPINE BESYLATE AND BENAZEPRIL HYDROCHLORIDE 1 tablet Oral		
Aftercare following joint replacement surgery			daily HTN		
Date			03/12/26		
13. ICD			8-HOUR BAYER 1 tablet Oral twice a day Blood clot		
Z96.652			Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, 1 tablet by mouth		
110.			every 4 hours As needed for pain		
Essential (primary) hypertension			Extra Strength Tylenol - Acetaminophen 500mg, 2 tablets by mouth every 6		
E78.00			hours As needed for pain		
Pure hypercholesterolemia unspecified			Ibuprofen - Ibuprofen 600 mg Take 1 tablet by mouth every 6 hours As		
Z85.42			needed for pain		
Personal history of malignant neoplasm of oth prt uterus			Colace - Docusate Sodium 100 mg , Take 1 tablet by mouth twice a day		
Z79.82			Stool softener		
Long term (current) use of aspirin					
Z79.1					
Long term (current) use of non-steroidal non-inflam (NSAID)					
Z79.891					
Long term (current) use of opiate analgesic					
Date			03/12/26		
14. DME and Supplies:			15. Safety Measures:		
bath bench, walker, cane			knee precautions, , , ambulates with device, walker precautions, , bathroom safety,		
16. Nutrition:			17. Allergies:		
low sodium			no known allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
Ambulation			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: No					
20. Prognosis: fair					
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.			family/caregiver will be responsible for managing treatment		
			patient 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.					
Clinical Condition <div>The patient is a 71-year-old female referred to home health services following an elective left total knee replacement, which Requiring Homecare:was reported to be uncomplicated. Her past medical history is significant for hypertension, hyperlipidemia, osteoarthritis, cataracts, and a history of endometrial cancer status post total hysterectomy. Upon assessment, the patient was alert and stable, with lung sounds clear to auscultation bilaterally. The surgical site over the left knee was covered with an Aquacel dressing, which remained intact with mild drainage noted but no signs or symptoms of infection observed. The patient resides in a two-story home with her family, with her bedroom located on the first floor. There are six steps with one handrail at the back entrance and a single step down into a sunken living room without a railing, posing potential safety concerns. Her daughter, who serves as the primary caregiver, and son were present during the visit. The home environment includes a pet dog, which may present an additional fall risk consideration. Functionally, the patient demonstrates deficits in gait, balance, strength, range of motion, transfers, bed mobility, and stair negotiation following surgery. During the visit, the patient participated in physical therapy interventions, including curb negotiation training using a rolling walker with two trials requiring minimal to contact guard assistance. A lower extremity home exercise program was initiated and instructed, including quadriceps sets, long arc quadriceps exercises, hip flexion, seated and supine heel slides, ankle pumps, and heel raises. The patient was also educated on medication compliance, proper use of ice and elevation for postoperative swelling management, and strategies for constipation prevention, likely related to decreased mobility and postoperative medications. A comprehensive medication review and physical assessment were completed during the visit. The patient demonstrates good rehabilitation potential and is expected to benefit from continued skilled physical therapy services to address current functional impairments, improve mobility and safety, and facilitate a return to prior level of function. The plan of care includes ongoing therapy focused on strengthening, balance training, gait training, transfer techniques, stair negotiation, and range of motion exercises, with continued caregiver education to support recovery and reduce risk of complications.</div><div> </div><div>Date of Order</div><div>03/12/2026</div><div>Orders</div><div>Physician Face-to-Face Date: 02/24/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left Total Knee Replacement</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>1 - SOC - SN Notes: soc</div><div>PT Eval Notes: eval</div><div>Physician</div><div>Narcisse, Patrick</div></div>					
SN Careplans			SN Goals		
SN WK1: 1 (03/12/26-03/14/26) ,WK2: 1 (03/15/26-03/21/26)			PATIENT-STATED GOAL: to walk without assistive devices		
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: 1. Non-agency caregiver(s) currently provide assistance			patient/caregiver recalls		
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8			* 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		
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 03/12/2026					
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 : 02/24/2026		
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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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:Durable power of attorney for health care/Medical power of attorney PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, limited strength, Pain Interference with ADLs, balance deficit, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Left Knee - Left knee replacement surgery PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee - Left knee replacement surgery: Remove dressing after 7 days post op and leave open to air. Cover with a dry gauze dressing if drainage occurs., cough/deep breathing exercises, incentive spirometer 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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, 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/caregiver recalls * strategies to minimize fatigue and exhaustion including work simplification * energy conservation * lifestyle changes * diet * recalls related medication(s) purpose, schedule patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule		
PT Careplans				PT Goals		
PT WK1: 1 (03/12/26-03/14/26) ,WK2: 3 (03/15/26-03/21/26) ,WK3: 2 (03/22/26-03/28/26)				PATIENT-STATED GOAL: To be able to walk normal again without pain in my knee		
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: Rom: Pt will improve L knee rom to 0 degrees extension amd 90+ degrees flexion with AAROM. , cough/deep breathing exercises, incentive spirometer, home exercise program: Laq, hip flexion, heelraises, aps, seated heelslides, straight leg raises, hamstring curls, equipment training, work simplification/energy conservation, 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				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 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 Sit to Stand - 06. Independent		
Signature of Physician:				Date		
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Optional Name/Signature of Nurse/Therapist:				Date		
Electronically Signed by Messick, Charles RN				03/12/2026		

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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 - 03. Partial/moderate assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent		Car Transfer - 06. Independent 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 Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Shower/Bathe Self - 03. Partial/moderate assistance Walk 10 Feet - 04. Supervision or touching assistance Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent		

Signature of Physician:	Date
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