Home Health Certification and Plan of Care

Order ID: 1150/17107

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
17163662	03/13/2026	From: 03/13/2026 To: 05/11/2026	22205	217058

6. Patient's Name and Address
John Novotny
2201 Greenspring Valley Drive,
Stevenson, MD 21153-
443-831-3573

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 08/16/1957 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
T84.52XA	Infect/inflm reaction due to internal left hip prosth init	03/13/26

13. ICD	Other Pertinent Diagnoses	Date
I77.819	Aortic ectasia unspecified site	03/13/26
G89.29	Other chronic pain	03/13/26
M54.50	Low back pain unspecified	03/13/26
M10.9	Gout unspecified	03/13/26
E66.3	Overweight	03/13/26
Z68.29	Body mass index [BMI] 29.0-29.9 adult	03/13/26
Z45.2	Encounter for adjustment and management of VAD	03/13/26
Z79.2	Long term (current) use of antibiotics	03/13/26
Z85.46	Personal history of malignant neoplasm of prostate	03/13/26

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

COLACE 100 mg / 1 Capsule by mouth twice a day
ALEVE 220 mg / 1 Capsule by mouth once a day
Ecotrin - Aspirin 81 mg / 1 Tablet by mouth twice a day for 28 days
Tylenol - Acetaminophen 500 mg / 1 Tablet by mouth every 6 hours as needed
Motrin - Ibuprofen 600 mg / 1 Tablet by mouth every 6 hours as needed .
Take with food
Zyloprim - Allopurinol 100 mg / 1 Tablet by mouth twice a day
Lipitor - Atorvastatin Calcium eq 40 mg base / 1 Tablet by mouth once a day
Oxaydo - Oxycodone Hydrochloride 0 5 mg, 1 tablet by mouth every 6 hours As needed for pain 5 or greater
Ceftriaxone - Ceftriaxone Sodium 2 gram intravenous once a day
ceftriaxone 2 gram daily for 6 weeks thru 4/20/26

14. DME and Supplies:
walker, 4 wheeled walker, PICC supplies

15. Safety Measures:
smoke detectors , , , , ambulates with device, ambulates with assistance, emergency phone # clearly displayed, hip precautions, no bp left arm, transfer with assist, , bathroom safety, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Up As Tolerated, Walker, Exercises Prescribed

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
family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Infection And Inflammatory Reaction Due To Internal Left Hip Prosthesis, Initial Encounter, 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 with a past medical history significant for dilated aortic root, prostate cancer status post robotic-assisted laparoscopic prostatectomy (2012), chronic low back pain, and gout, who underwent a left total hip replacement on 02/19/2026. Approximately two and a half weeks postoperatively, the patient developed symptoms concerning for infection, including fever, chills, night sweats, malaise, decreased appetite, and erythema at the surgical site. Subsequent evaluation revealed laboratory findings of leukocytosis (WBC 11.7), elevated neutrophils (9.91), ESR of 27, CRP of 217, and lactic acid of 1.6, consistent with suspected surgical site infection. The patient underwent surgical exploration with irrigation and debridement of the left hip. Intraoperative findings included a small pocket of purulent fluid superficial to the fascia, which was cultured, and joint fluid was obtained for further analysis. The surgical site was thoroughly irrigated, and the polyethylene liner and femoral head components were exchanged. The wound was closed, and an Aquacel dressing was applied. No intraoperative complications were reported. Postoperatively, the patient was initially treated with intravenous Unasyn and Daptomycin and has since been transitioned to intravenous Ceftriaxone therapy at home via a peripherally inserted central catheter (PICC) line. The current regimen includes Ceftriaxone 2 g IV daily with a 10 mL normal saline flush following each infusion, scheduled for a total duration of six weeks from 03/13/2026 through 04/20/2026. Orders include PICC line care and dressing changes per established protocol, as well as weekly laboratory monitoring, including complete blood count and serum creatinine. Laboratory results are to be communicated to the infectious disease specialist for ongoing management. At the time of assessment, the patient is homebound due to recent surgery, postoperative infection, decreased endurance, and the need for assistance with mobility. Skilled nursing services are required for PICC line management, administration and monitoring of IV antibiotic therapy, weekly lab draws, ongoing assessment of surgical site healing, infection surveillance, and patient education regarding medication adherence, PICC line care, and recognition of signs and symptoms of infection requiring prompt reporting. A physical therapy evaluation was completed. Prior to surgery, the patient was independent with ambulation without the use of an assistive device. Currently, the patient demonstrates near baseline strength, with bilateral lower extremity strength assessed at approximately 3+/5 and mild stiffness noted in the left hip. Functional assessment using the 30-second chair rise test yielded a score of 8, indicating adequate strength and endurance. The patient is able to ambulate safely without an assistive device and demonstrates understanding of hip precautions. A home exercise program focusing on standing therapeutic exercises and left hip mobility within prescribed precautions was initiated, and the patient demonstrated the ability to perform exercises safely and correctly. No further skilled physical therapy services are indicated at this time. The plan of care includes continued skilled nursing services to support IV antibiotic therapy, monitor recovery, and prevent complications, with the goal of full resolution of infection and return to prior level of function.
 Date of Order 03/13/2026 Orders Physician Face-to-Face Date: 03/11/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN - Skilled assessment, medication management, vitals monitoring, wound care, IV infusion, PT - Evaluation and treatment, reach strength training exercises due to Infection and inflammatory reaction due to internal left hip prosthesis, initial encounter 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:
 Physician Watts, Charlotte

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/13/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Charlotte Watts
2391 Greenspring Dr
Timonium, MD 21093
PHONE: 4103395500 FAX: 14103395960 NPI: 1336481951

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 : 03/11/2026

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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SN WK1: 1 (03/13/26-03/14/26) ,WK2: 1 (03/15/26-03/21/26) ,WK3: 1 (03/22/26-03/28/26) ,WK4: 1 (03/29/26-04/04/26) ,WK5: 1 (04/05/26-04/11/26) ,WK6: 1 (04/12/26-04/18/26)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 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; 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: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, dependent edema, limited endurance, swelling of affected area, limited strength, muscle weakness, Pain Interference with Therapy activities, balance deficit, Pain Interference with ADLs, Pain Effect on Sleep, bruising/discoloration, red/tender pressure points, swell/redness surround. skin, #1 - Observable Surgical Wound - Other - Left Hip - Left surgical hip wound

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Other - Left Hip - Left surgical hip wound, incentive spirometer, physician-ordered wound care, teach/coordinate/arrange medication packaging and/or administration, infusion therapy: Patient will need IV Ceftriaxone 2g administered followed by a 10ml NS flush of the line after infusion daily for 6 weeks start date was 3/13/2026 and the end date will be 4/20/2026. PICC line dressing changes per protocol. Prescription has been placed through Kaiser EPIC system. He will need weekly CBC and CRP labs while on treatment. Labs may be faxed to Dr. Eilertson with Infectious Disease at 410-847-3380.

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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

PATIENT-STATED GOAL: Patient states he wants to return back to work as he works at the Maryvale school.

GOALS
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
* 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
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

PT Careplans

PT WK2: 1 (03/15/26-03/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, GG0170E1 - Chair to Bed to Chair, 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, 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: Medication Review: - medications reviewed with patient/caregiver, home exercise program: Hep established: Standing heel/ toe raises, knee flex, hip flex to 90 degrees, hip abd, partial squats 1x10 daily, gait training/stair training

PT Goals

PATIENT-STATED GOAL: To go back to work

Signature of Physician:

Date

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

Date
03/13/2026