Home Health Certification and Plan of Care

Order ID: 1150/17769

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
11230029	04/03/2026	From: 04/03/2026 To: 06/01/2026	23737	217058

6. Patient's Name and Address

Henson Spencer
515 Old Oak road,
Severn, MD 21144-
443-336-3488

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 04/21/1953 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	04/03/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	04/03/26
M19.042	Primary osteoarthritis left hand	04/03/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	04/03/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	04/03/26
N18.31	Chronic kidney disease stage 3a	04/03/26
E11.36	Type 2 diabetes mellitus with diabetic cataract	04/03/26
E78.5	Hyperlipidemia unspecified	04/03/26
M51.379	Other intervertebral disc degeneration lumbosacral region	04/03/26
K21.9	Gastro-esophageal reflux disease without esophagitis	04/03/26
M10.9	Gout unspecified	04/03/26
N52.9	Male erectile dysfunction unspecified	04/03/26
E66.9	Obesity unspecified	04/03/26
Z68.34	Body mass index [BMI] 34.0-34.9 adult	04/03/26
Z79.82	Long term (current) use of aspirin	04/03/26
Z90.49	Acquired absence of other specified parts of digestive tract	04/03/26
Z86.0100	Personal history of colonic polyps	04/03/26

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

GLUCOTROL 10 mg 10 mg / 1 Tablet by mouth in the morning 30 minutes before a meal for Diabetes
MOBIC 15 mg / 1 Tablet by mouth daily
PEPCID 40 mg / 1 Tablet by mouth daily
LIPITOR 40 mg / 1 Tablet by mouth daily for cholesterol
ZYLOPRIM 100 mg/tablet / Take 2 tablets by mouth daily
Aspercreme 4 % Top PTMD Patch / Apply 1 patch to skin topical once a day may remain in place for up to 12 hours in a 24-hour period
HYDROCHLOROTHIAZIDE 12.5 mg / 1 Tablet by mouth every morning
Ventolin - Albuterol 90 mcg/actuation Inhl HFAA / Inhale 2 Puffs by mouth every 4 hours as needed (rescue inhaler)
Multivitamin-Minerals Oral Tab 1 Tablet Oral once a day
ASPIRIN 80 mg / 1 Tablet Oral once daily
Aspirin 81Mg - Aspirin 2 tablets by mouth twice a day Heart
Oxycodone 5/Apap 500 - Acetaminophen: Oxycodone Hydrochloride 500 mg;5 mg 5mg 1-2 tabs by mouth every hour As Needed for pain
Ibuprofen - Ibuprofen 800 mg 1 tab by mouth every hour As-needed for pain
Tylenol - Acetaminophen 500 mg, Take 2 tablet (1,000 mg total) by mouth every hour Ax needed for pain
Colace - Docusate Sodium 100 mg 1-2 tabs by mouth once a day As needed for constipation

14. DME and Supplies:

grab bars, cane, rolling walker

15. Safety Measures:

walker precautions, medication safety, diabetic precautions, ambulates with device, bathroom safety, standard precautions, knee precautions, ambulates with assistance, fall precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

amitriptyline hydrochloride metformin

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., 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

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

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 a 72-year-old male with a past medical history of bilateral knee osteoarthritis, status post left total knee replacement, currently receiving skilled nursing services for postoperative care, monitoring, and follow-up. He is alert and oriented 3 and was observed resting comfortably in a recliner during the visit, with his wife present. The patient denies chest pain or discomfort and reports a pain level of 6/10 at the surgical site, managed with prescribed pain medication and use of a cold therapy unit. The non-removable surgical dressing is dry and intact, with planned removal on 4/10/26. Mild bilateral lower extremity edema is noted, and the patient is compliant with prescribed TED stockings. He reports his last bowel movement was two days ago and is currently on a bowel regimen, with education provided regarding stool softener use. Medications were reviewed with no discrepancies or refill needs. Functionally, the patient ambulates with a walker and intermittently uses a cane in tight spaces, performs transfers with good control, and demonstrates appropriate technique with stair navigation using a railing. Education was provided regarding expected postoperative swelling, bruising, and pain management to support participation in therapy. The patient has a follow-up appointment with the surgeon on 4/19/26 and is scheduled to begin outpatient physical therapy on 4/20/26. He agrees with the plan of care, and continued skilled nursing monitoring is indicated.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 04/03/2026
 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 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 Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/03/2026

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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SN WK1: 2 (04/03/26-04/04/26)

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: 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 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; 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: M1700 - Cognition, M1720 - Anxiety, meal preparation, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, bruising/discoloration, discolored patches of skin, swell/redness surround. skin

PROCEDURES: cough/deep breathing exercises, incentive spirometer, 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., glucose testing via monitor, 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 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related medication(s) purpose, schedule, * how to keep home safe for patient with dementia coping strategies for the caregiver*, 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, caregiver administers and/or packages medications appropriately

PATIENT-STATED GOAL: Patient wants to be able to return to driving , so he can access community resources

GOALS
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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* 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

PT Careplans

PT Goals

Signature of Physician:

Date

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

Date
04/03/2026

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PT WK1: 2 (04/03/26-04/04/26) ,WK2: 3 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26)

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: cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation, 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, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: Patient wants to be able to return to driving , so he can access community resources

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

Chair to Bed to Chair - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Toilet Transfer - 06. Independent

Car Transfer - 06. Independent

Walk 150 Feet - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Don/Doff Footwear - 06. Independent

4 Steps - 05. Setup or clean-up assistance

Eating - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Oral Hygiene - 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

Sit to Stand - 06. Independent

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/03/2026