Home Health Certification and Plan of Care

Order ID: 1150/17783

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
661082474	04/03/2026	From: 04/03/2026 To: 06/01/2026	23738	217058

6. Patient's Name and Address

Gail Ogin
1321Malbay Dr,
LUTHERVILLE TIMONIUM, MD 21093-
410-821-8361

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 01/09/1948 | **9.Sex** Female

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

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	04/03/26
M17.12	Unilateral primary osteoarthritis left knee	04/03/26
M79.7	Fibromyalgia	04/03/26
E78.5	Hyperlipidemia unspecified	04/03/26
I87.2	Venous insufficiency (chronic) (peripheral)	04/03/26
I70.0	Atherosclerosis of aorta	04/03/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	04/03/26
M47.22	Other spondylosis with radiculopathy cervical region	04/03/26
G47.00	Insomnia unspecified	04/03/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	04/03/26
M54.16	Radiculopathy lumbar region	04/03/26
M48.02	Spinal stenosis cervical region	04/03/26
M48.061	Spinal stenosis lumbar region without neurogenic claud	04/03/26
K76.89	Other specified diseases of liver	04/03/26
H91.91	Unspecified hearing loss right ear	04/03/26
K21.9	Gastro-esophageal reflux disease without esophagitis	04/03/26
K58.9	Irritable bowel syndrome without diarrhea	04/03/26
E66.01	Morbid (severe) obesity due to excess calories	04/03/26
Z68.35	Body mass index [BMI] 35.0-35.9 adult	04/03/26
Z79.51	Long term (current) use of inhaled steroids	04/03/26
Z86.0102	Personal history of hyper	04/03/26

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

Nystatin-Triamcinolone Top Cream 0.1 %-Zinc Oxide Paste 20 % in Equal Parts topical twice a day During flares: Apply this topical steroid medication to affected areas twice daily no more than 5 days a week. Decrease frequency of use after skin improves.
PRILOSEC SR 20 mg / 1 Capsule by mouth 2 times a day
CYMBALTA SR 20 mg / 1 Capsule by mouth daily
ZOCOR 40 mg / 1 Tablet by mouth in the evening
RETIN-A 0.1 % Top Cream / Apply to affected area(s) topical at bedtime Apply a pea size amount to entire face every other night for 2 weeks, then increase to nightly.
FIBERCON 625 mg / 1 Tablet by mouth twice a day (Patient taking differently: Take 625 mg by mouth daily)
FLORASTOR 250 mg / 1 Capsule Oral once a day
Fluticasone-Salmeterol (WIXELA INHUB) 250-50 mcg/dose Inhl Disk w/devi / Inhale 1 puff by mouth twice a day (Controller inhaler)
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 mg=1tab by mouth every 6 hours 1-2 tabs every 6 hours as needed for pain

14. DME and Supplies:

rolling walker, walker, 4 wheeled walker

15. Safety Measures:

walker precautions, restricted ROM, medication safety, fall precautions, bleeding precautions, ambulates with device, ambulates with assistance, knee precautions, emergency phone # clearly displayed, supervision at all times, transfer with assist, standard precautions, bathroom safety, anticoagulant precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

atorvastatin doxyclycline metronidazole naproxen tetracycline vibraymycin

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: NA Patient nonresponsive, 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

SN: family/caregiver will be responsible for managing treatment PT: another fac

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.

Clinical Condition Requiring Homecare:

The patient is a 78-year-old female admitted to home health services following a right total knee arthroplasty performed for chronic osteoarthritis associated with severe preoperative pain and decreased mobility. Postoperatively, she reports severe right knee pain rated at 10/10, currently managed with prescribed analgesics, and denies chest pain or shortness of breath. The surgical incision is intact with no signs of infection, though mild to moderate swelling is present. She ambulates with a walker, demonstrates limited weight-bearing tolerance, and requires assistance with transfers and activities of daily living, including bathing, dressing, and toileting. The patient is homebound due to recent surgery, pain, weakness, impaired mobility, and increased fall risk, requiring considerable effort and assistance to leave the home safely. She resides with her husband in a single-family home and has documented allergies to atorvastatin, doxycycline, metronidazole, naproxen, tetracycline, and Vibramycin. She is a full code with a MOLST on file and is scheduled to begin outpatient therapy in approximately three weeks. During the visit, she demonstrated poor pain tolerance, requiring assistance with therapeutic exercises, including heel slides and short arc quadriceps exercises, and ambulated approximately 150 feet with a walker but tolerated the session poorly.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 04/03/2026
 Physician Face-to-Face Date: 03/20/2026
 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;

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 : 03/20/2026

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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background-clip: initial;"><o:p></o:p> Physician: Narcisse, Patrick

SN Careplans

SN WK1: 1 (04/03/26-04/04/26) ,WK2: 1 (04/05/26-04/11/26)

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:MOLST

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, dependent edema, muscle weakness, limited range of motion, limited endurance, limited strength, swelling of affected area, Pain Effect on Sleep, daytime fatigue, balance deficit, difficulty sleeping, Pain Interference with ADLs, Pain Interference with Therapy activities, loss of appetite, swell/redness surround. skin, bruising/discoloration, #1 - Non-Observable Surgical Wound - Other - right knee - R RKA

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - right knee - R RKA: 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., apply anti-embolitic stockings, 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, * how to keep home safe for patient with dementia coping strategies for the caregiver*, 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

SN Goals

PATIENT-STATED GOAL: Patient states she wants to be able to walk up and down the stairs again without any pain

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
* 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
* 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 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

caregiver administers and/or packages medications appropriately

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

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, strengthening exercises: Heel slides, slr, le abd/add, long arc , marching , heel raises and stair 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 - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, 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

PATIENT-STATED GOAL: To walk without pain

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

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

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