Home Health Certification and Plan of Care

Order ID: 1150/17592

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
2D41C05YD35	03/27/2026	From: 03/27/2026 To: 05/25/2026	24136	217058

6. Patient's Name and Address
Alfred Luebben
8904 Lennings Lane,
Rosedale, MD 21237-
410-687-4336

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 11/10/1951 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
T84.53XD	Infect/inflm reaction due to internal r knee prosth subs	03/27/26

13. ICD	Other Pertinent Diagnoses	Date
B95.61	Methicillin suscep staph infct causing dis classd elswhr	03/27/26
M00.269	Other streptococcal arthritis unspecified knee	03/27/26
I27.20	Pulmonary hypertension unspecified	03/27/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	03/27/26
I50.32	Chronic diastolic (congestive) heart failure	03/27/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	03/27/26
N18.30	Chronic kidney disease stage 3 unspecified	03/27/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	03/27/26
J96.12	Chronic respiratory failure with hypercapnia	03/27/26
G25.81	Restless legs syndrome	03/27/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	03/27/26
M35.3	Polymyalgia rheumatica	03/27/26
I89.0	Lymphedema not elsewhere classified	03/27/26
F41.9	Anxiety disorder unspecified	03/27/26
D69.6	Thrombocytopenia unspecified	03/27/26
M48.00	Spinal stenosis site unspecified	03/27/26
R33.9	Retention of urine unspecified	03/27/26
E66.01	Morbid (severe) obesity due to excess calories	03/27/26
Z68.41	Body mass index [BMI] 40.0-44.9 adult	03/27/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	03/27/26
Z79.01	Long term (current) use of anticoagulants	03/27/26
Z79.4	Long term (current) use of insulin	03/27/26
Z99.89	Dependence on other enabling machines and devices	03/27/26
Z95.5	Presence of coronary angioplasty implant and graft	03/27/26

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

TORSEMIDE 20 mg/tablet / Take 40 mg 2 tab PO Daily Indication: Edema-congestive heart failure
Tamsulosin Hydrochloride - Tamsulosin Hydrochloride 0.4 mg / 1 Capsule by mouth once a day Indication: Other, AUR
SILDENAFIL CITRATE mg 1 tab PO 3x/day Indication: Pulmonary hypertension
SERTRALINE mg 1 tab PO Daily Indication: Depression
Senna - Senna 8.6 mg / 1 Tablet by mouth twice a day Indication: Constipation
ROSUVASTATIN CALCIUM mg 1 tab PO Daily Indication: Cardiovascular system dz
MODAFINIL 200 mg 1 tab PO once a day with breakfast. Indication: Obstructive sleep apnea
RANOLAZINE ER 500 mg 1 tab PO 2x/day Indication: Angina pectoris, chronic
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 mg/tablet / Take 7.5 mg 1.5 tablet by mouth every 4 hours Indication: Pain PRN Reason: pain, severe (7 to 10)
Polyethylene Glycol 3350 - Polyethylene Glycol 3350 17 gm PO Daily PRN Reason: constipation, Indication: Constipation
OXYCODONE 5 mg 1 tab PO q6h Indication: Pain PRN Reason: pain, moderate (4 to 6)
Metoprolol - Hydrochlorothiazide: Metoprolol Succinate ER 25 mg / 1 Tablet by mouth in the evening
MELATONIN mg 1 tab PO Nightly PRN Reason: insomnia, Indication: Insomnia
Insulin Lispro COD (per unit) 1,000 unit/10mL / 10 units subcutaneous once a day with meals. Indication: Diabetes mellitus
Insulin Glargine Inj (per unit) 37 units subcutaneous in the evening Indication: Diabetes mellitus
HYDRALAZINE 100 mg 1 tab PO three times a day Indication: Hypertension
Glucose 40 % Oral Gel 15 gm 1 ea by mouth as necessary T2DM
ACETAMINOPHEN mg 2 tab PO q8h Indication: Pain
ACETAZOLAMIDE mg 1 tab PO Daily Indication: Edema
Aspirin Ec - Aspirin 81 mg 1 tab PO Daily Indication: Cardiovascular Disease
Cefazolin 2 gm / Inj 2 gm intravenous every 8 hours IV Push q8h-int Indication: Empiric severe infection
CLOPIDOGREL mg 1 tab PO Daily Indication: Platelet aggregation inhibitor

14. DME and Supplies:
wheelchair, walker, IV supplies, diabetic supplies, bath bench

15. Safety Measures:
walker precautions, , , knee precautions, , diabetic precautions, , bathroom safety, , ambulates with device

16. Nutrition:
diabetic

17. Allergies:
losartan (Mild) Throat irritation, Swelling of throat, Augmentin, Lyrica swelling, r

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
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:
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 right knee 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 74-year-old male with a complex medical history including obesity, <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-18 CE-FMS-diabetes">diabetes</mh> mellitus, coronary artery disease, chronic kidney disease, obstructive sleep apnea, neuropathy, polymyalgia rheumatica, chronic lymphedema, and prior right total knee replacement in 2024. On 03/19/2026, he experienced acute onset of severe right knee pain upon awakening and was subsequently evaluated in the emergency department, where laboratory findings revealed leukocytosis and elevated neutrophils. He was diagnosed with septic arthritis of the right knee and admitted for intravenous antibiotic therapy. Surgical intervention included revision of the right total knee arthroplasty with replacement of femoral and tibial components and removal of the patellar component. The patient was later discharged following hospitalization and subacute rehabilitation and is now receiving home health services. The patient currently has a right-sided single-lumen tunneled powerline catheter in place for administration of intravenous antibiotics. He is prescribed Cefazolin 2 grams every 8 hours, administered via IV push using a 10 mL syringe over approximately 5 minutes. Comprehensive education was provided to the patient and caregivers regarding IV medication administration, including proper hand hygiene, infection prevention, and adherence to dosing schedule. The patient's wife and daughter were instructed to administer the medication incrementally (1 mL at intervals to complete the dose over 5 minutes) and demonstrated understanding of the procedure. Weekly

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/27/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Jessica Sewell
103 Bata Boulevard
Belcamp, MD 21017
PHONE: 4105756611 FAX: 14103672141 NPI: 1205803533

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 : 03/23/2026

27. Attending Physician's Signature and Date Signed **04/06/2026** 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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central line dressing changes and laboratory monitoring, including CBC and BMP, are planned to assess response to therapy and monitor for complications. The surgical site staples were removed on 03/26/2026. The incision was initially covered with a foam dressing with underlying Steri-Strips; however, per surgeon's guidance, the site is now to remain open to air with Steri-Strips intact. The patient was instructed on appropriate wound care, including allowing soap and water to run over the incision during showering without scrubbing or soaking, followed by gentle drying. No signs of infection were reported at the time of assessment. A full medication reconciliation was completed with the patient and family. Functionally, the patient demonstrates significant decline from his prior level of independence. Prior to hospitalization, he ambulated independently within the home using a single-point cane and utilized a rolling walker for community ambulation, with independence in transfers, bed mobility, and activities of daily living. Currently, he presents with right lower extremity weakness, decreased range of motion, impaired weight-bearing tolerance, and significant mobility limitations. He requires maximal assistance for sit-to-stand and stand-pivot transfers and is unable to ambulate effectively, demonstrating only minimal ability to take steps in place with poor advancement of the right lower extremity. He currently ambulates with a walker for limited mobility but remains largely dependent on assistance. Balance is impaired, and he is at high risk for falls. Skilled physical therapy interventions have been initiated, focusing on weight shifting, transfer training, and initiation of a lower extremity home exercise program to address strength and mobility deficits. Education has been provided on safe use of assistive devices, fall prevention strategies, and adherence to prescribed exercises. The plan of care includes continued skilled nursing for central line management, IV antibiotic administration, wound monitoring, and laboratory surveillance, as well as ongoing physical therapy to improve strength, range of motion, balance, and functional mobility. The patient remains homebound due to significant mobility limitations, need for assistive devices, and high fall risk. With continued multidisciplinary care and adherence to the treatment plan, the patient has potential to improve functional status and progress toward prior level of independence.
 Date of Order 03/27/2026 Orders Physician Face-to-Face Date: 03/23/2026 Clinical Condition Requiring Home Care per Certifying Physician: Muscle Weakness, Generalized Weakness and Fatigue, Pain due to Infection and inflammatory reaction due to internal right knee 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: OT Eval Notes:
 Physician Sewell, Jessica

SN Careplans

SN WK1: 1 (03/27/26-03/28/26) ,WK2: 1 (03/29/26-04/04/26) ,WK3: 1 (04/05/26-04/11/26) ,WK4: 1 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26)

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, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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, abnormal BS < 70/140 > mg/dL, limited strength, Pain Interference with ADLs, balance deficit, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Knee - Right knee revision surgery

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Knee - Right knee revision surgery: Leave Steri strips in place to fall off on their own and leave the

SN Goals

PATIENT-STATED GOAL: to walk without assistive devices

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/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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/27/2026

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surgical site open to air., glucose testing via monitor

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

PT Careplans

PT WK2: 2 (03/29/26-04/04/26) ,WK3: 2 (04/05/26-04/11/26) ,WK4: 2 (04/12/26-04/18/26) ,WK5: 1 (04/19/26-04/25/26) ,WK6: 1 (04/26/26-05/02/26) ,WK7: 1 (05/03/26-05/09/26) ,WK8: 1 (05/10/26-05/16/26) ,WK9: 1 (05/17/26-05/23/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170R1 - Wheel 50 ft w 2 Turns, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, GG0170S1 - Wheel 150 feet, GG0170F1 - Toilet Transfer, 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, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand

PROCEDURES: Medication management : Review medication with pt, cough/deep breathing exercises, incentive spirometer, wheelchair training, home exercise program: Seated heel slides, laq, hip flexion, heelraises, toe raises,knee flexion and extension stretching, standing TKES RLE in rw 3 second holds, 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 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 - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Wheel 50 ft w 2 Turns - 06. Independent, Car Transfer - 05. Setup or clean-up 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

PT Goals

PATIENT-STATED GOAL: To be able to walk again and stand without help

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

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

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

4 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Wheel 50 ft w 2 Turns - 06. Independent

Car Transfer - 05. Setup or clean-up 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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/27/2026