Home Health Certification and Plan of Care

Order ID: 1150/18442

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
441020687	05/01/2026	From: 05/01/2026 To: 06/29/2026	24911	217058

6. Patient's Name and Address

Natalie Taylor
5628 Triplett Rd,
OWINGS MILLS, MD 21117-
443-938-8917

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 10/04/1960 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	05/01/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	05/01/26
M17.12	Unilateral primary osteoarthritis left knee	05/01/26
E55.9	Vitamin D deficiency unspecified	05/01/26
M79.2	Neuralgia and neuritis unspecified	05/01/26
Q62.5	Duplication of ureter	05/01/26
E03.9	Hypothyroidism unspecified	05/01/26
E66.01	Morbid (severe) obesity due to excess calories	05/01/26
Z68.38	Body mass index [BMI] 38.0-38.9 adult	05/01/26
Z90.722	Acquired absence of ovaries bilateral	05/01/26
Z90.710	Acquired absence of both cervix and uterus	05/01/26
Z90.89	Acquired absence of other organs	05/01/26
Z85.43	Personal history of malignant neoplasm of ovary	05/01/26
Z85.850	Personal history of malignant neoplasm of thyroid	05/01/26

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

Synthroid - Levothyroxine Sodium 100 mcg / 1 Tablet by mouth once a day on Monday through Saturday and skip Sunday. Please have follow-up thyroid labs done
Tramadol - Tramadol Hydrochloride 50mg by mouth every 6 hours As needed for pain
Ibuprofen - Ibuprofen 600 mg by mouth every 6 hours As needed for pain
Colace - Docusate Sodium 100mg by mouth twice a day
Asa - Aspirin 81mg by mouth twice a day
Acetaminophen - Acetaminophen 500mg by mouth every 8 hours As needed for pain

14. DME and Supplies:

walker

15. Safety Measures:

walker precautions, medication safety, knee precautions, fall precautions, bathroom safety, ambulates with device

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

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: 1. Rarely, 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

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

Homebound status: After undergoing Right total knee arthroplasty, 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 65-year-old female admitted to home health services status post right total knee arthroplasty performed on 04/30/2026. Past medical history is significant for bilateral leg neuralgia, osteoarthritis of both knees, and prior reproductive surgeries. Upon assessment, the patient was observed sitting upright in a chair in her living room with bilateral lower extremities elevated and an ice pack applied to the operative knee. Patient denied pain at the time of assessment and appeared in no acute distress. Vital signs were obtained and noted as follows: temperature 97.3F, oxygen saturation 96% on room air, pulse 62 bpm, and blood pressure 108/60 mmHg. Lung sounds were clear to auscultation bilaterally, bowel sounds were active in all quadrants, and peripheral pulses were palpable in all four extremities. Patient reported last bowel movement occurred yesterday and denied postoperative nausea, vomiting, shortness of breath, chest pain, dizziness, or lightheadedness. Assessment of the surgical site revealed the dressing to be clean, dry, and intact with no drainage or signs of complication observed. Surgical dressing was assessed and photographed per agency protocol. Patient continues to utilize elevation and ice therapy appropriately for postoperative edema and pain management. Education was reinforced regarding incision care, signs and symptoms of infection, fall prevention, pain management strategies, medication compliance, hydration, and activity pacing during recovery. Physical therapy evaluation was completed for postoperative rehabilitation needs. Patient presents with postoperative right lower extremity weakness, pain-limited range of motion, impaired balance, decreased endurance, and altered gait mechanics following right total knee replacement surgery. Static balance was assessed as fair minus, while dynamic balance ranged from poor to fair, contributing to increased fall risk. Gait was noted to be antalgic with decreased right stance time and shortened step length. Patient ambulates approximately 30 to 50 feet using a rolling walker with standby assistance for safety. Transfers require standby assistance with increased time and upper extremity support secondary to pain, weakness, and decreased stability. Due to postoperative pain, impaired mobility, decreased endurance, and need for assistive device and supervision for safe ambulation, the patient is considered homebound. Skilled home health physical therapy services are medically necessary to address deficits in strength, range of motion, gait, balance, endurance, transfer ability, and overall functional mobility. Treatment plan includes therapeutic exercises for postoperative strengthening, range of motion restoration, gait and transfer training, balance retraining, edema and pain management, safety education, and progression toward maximal functional independence while reducing risk for falls and postoperative complications.
 Date of Order 05/01/2026 Orders Physician Face-to-Face Date: 04/17/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right total knee arthroplasty 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: eval
 Physician Narcisse, Patrick

SN Careplans	SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/01/2026

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 : 04/17/2026

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 (05/01/26-05/02/26) ,WK2: 1 (05/03/26-05/09/26)

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

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: M2020 - Oral Med Management, M1400 - Dyspnea, swelling of affected area, muscle weakness, limited range of motion, limited strength, balance deficit, obesity, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Knee -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Knee -: Remove surgical dressing seven days after surgery., 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 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

PATIENT-STATED GOAL: I want to walk without the cane

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
* 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

PT Careplans

PT WK1: 1 (05/01/26-05/02/26) ,WK2: 3 (05/03/26-05/09/26) ,WK3: 2 (05/10/26-05/16/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, 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, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: B LE strengthening: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., gait training/stair training, transfers training

PT Goals

PATIENT-STATED GOAL: To have a successful post surgical outcome

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Signature of Physician:

Date

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

Date
05/01/2026

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TEACH PATIENT/CAREGIVER: * 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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 - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 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 - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
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