Home Health Certification and Plan of Care

Order ID: 1150/19452

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
41110831	06/05/2026	From: 06/05/2026 To: 08/03/2026	26049	217058

6. Patient's Name and Address

Mary Franz-Rohrer
16 Manor Ave,
BALTIMORE, MD 21206-
443-695-0510

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 10/26/1951 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	06/05/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	06/05/26
E78.00	Pure hypercholesterolemia unspecified	06/05/26
F33.42	Major depressive disorder recurrent in full remission	06/05/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/05/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	06/05/26
L82.1	Other seborrheic keratosis	06/05/26
H90.3	Sensorineural hearing loss bilateral	06/05/26
F41.9	Anxiety disorder unspecified	06/05/26
E66.9	Obesity unspecified	06/05/26
Z68.33	Body mass index [BMI] 33.0-33.9 adult	06/05/26
Z86.711	Personal history of pulmonary embolism	06/05/26
Z87.891	Personal history of nicotine dependence	06/05/26
Z79.82	Long term (current) use of aspirin	06/05/26
Z79.1	Long term (current) use of non-steroidal non-inflam (NSAID)	06/05/26
Z79.891	Long term (current) use of opiate analgesic	06/05/26
Z96.1	Presence of intraocular lens	06/05/26
Z97.4	Presence of external hearing-aid	06/05/26

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

CRESTOR 20 mg 20 mg / 1 Tablet by mouth daily
Wellbutrin Xl - Bupropion Hydrochloride 300 mg / 1 Tablet by mouth every morning
DRISDOL 1,250 mcg (50,000 unit) / 1 Capsule by mouth every 7 days
LAMICTAL 200 mg 200 mg / 1 Tablet by mouth every morning (alembic brand only, ndc 62332-0040-60)
ZOLOFT 100 mg/tablet / Take 2 tablets by mouth every morning
DESYREL 50 mg/tablet / Take half tablet by mouth daily at bedtime
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 4 hours For s/p surgical pain
Colace - Docusate Sodium 100mg by mouth twice a day 1-2 tabs fipor bowel regimen
Aspirin 81Mg - Aspirin 81mg by mouth twice a day
Cpap - Cpap 4 inhalant at bedtime

14. DME and Supplies:

walker, cane

15. Safety Measures:

walker precautions, standard precautions, supervision at all times, knee precautions, fall precautions, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

low cholesterol

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

Walker, 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: Yes

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

patient will be responsible for managing treatment

Homebound status: After undergoing Left total knee replacement, 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:

Patient is a 74-year-old individual admitted to home health services following a recent left total knee replacement surgery performed by Dr. Narcisse. The patient's past medical history is significant for osteoarthritis of the right knee with previous right knee replacement. Consent for treatment was obtained and signed by the patient. Due to recent surgery, postoperative pain, impaired mobility, and the need for a walker with one-person assistance for safety, the patient is considered homebound, as leaving the home requires considerable and taxing effort. Upon assessment, the patient was alert and oriented to person, place, time, and situation (A&O x4). The patient reported severe left knee pain rated 9/10, which was attributed to overexertion after walking to let the dog inside and standing in the kitchen for an extended period. The patient denied any recent falls, dizziness, or lightheadedness. The patient ambulates approximately 30 feet on indoor surfaces using a rolling walker with verbal cues for proper gait pattern and safety. Transfers from bed and recliner require supervision, and bed mobility is performed with supervision, utilizing the upper extremities to assist in lifting the lower extremities onto the bed. Outdoor ambulation, stair negotiation, and car transfer abilities were not assessed during this visit. The patient resides alone in a single-family home with four steps required to enter the residence; however, the bedroom and bathroom are located on the first floor, allowing for safer access during recovery. Functional assessment revealed a Tinetti Balance and Gait score of 12/28, indicating a high risk for falls. The patient reported the last bowel movement occurred the previous day. Appetite was described as fair, and the patient reported current nausea without vomiting. The patient plans to contact the nurse advice line to request a prescription for ondansetron (Zofran) for nausea management. The patient denied urinary complaints, including pain or difficulty with urination. Cardiopulmonary assessment was unremarkable, with lungs clear to auscultation bilaterally and no signs of respiratory distress noted. Incentive spirometer use was reviewed and reinforced to promote optimal pulmonary function during postoperative recovery. Assessment of the surgical site revealed the postoperative dressing to be intact, with no abnormal bleeding reported. No additional wounds or skin concerns were identified during the visit. The patient was instructed to keep the surgical dressing clean, dry, and intact and to avoid getting the dressing wet or soaking the incision area. Education was provided regarding signs and symptoms of infection and complications, including increased pain, swelling, bruising, redness, drainage, fever, or abnormal bleeding, with instructions to notify the surgeon immediately should any of these occur. A follow-up skilled nursing visit was discussed, during which the dressing will be removed, the incision site assessed, measured, and photographed according to agency protocol. Medication reconciliation was completed, and all medications were reviewed with the patient to ensure understanding and compliance. The patient was informed that Motrin therapy would begin the following day and received education regarding appropriate pain management strategies, including the use of prescribed medications, anti-inflammatory agents, and non-pharmacological interventions. Ice therapy was recommended for 20 minutes several times daily to assist with pain and swelling control. The patient was also instructed to elevate the left lower extremity above the level of the heart to reduce postoperative edema, maintain adequate hydration

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/05/2026

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 : 05/22/2026

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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to prevent dehydration, and advance the diet slowly as tolerated to minimize nausea. Physical therapy evaluation demonstrated decreased strength, impaired gait mechanics, reduced functional mobility, and limited range of motion of the left knee, measured at 0 to 65 degrees. Therapeutic exercises were initiated and tolerated well, including sitting knee extensions, ankle pumps, supine quadriceps sets, short arc quadriceps exercises, hip flexion, straight leg raises, and hip abduction exercises. The patient was instructed to perform the prescribed home exercise program consistently, ambulate several times daily as tolerated, and follow all postoperative precautions and recommendations. Skilled nursing and physical therapy services are medically necessary to provide ongoing postoperative assessment, pain management, wound monitoring, medication education, fall prevention, gait and transfer training, strengthening exercises, range-of-motion progression, and overall rehabilitation following left total knee replacement. Continued home health intervention is expected to improve strength, mobility, safety, functional independence, and recovery while reducing the risk of complications and rehospitalization.
 Date of Order 06/05/2026 Orders Physician Face-to-Face Date: 05/22/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control, PT-eval & treat due to Left total knee replacement 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 WK1: 1 (06/05/26-06/06/26) ,WK2: 1 (06/07/26-06/13/26)

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; 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 ; 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.

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.
Advance Directive:Yes

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0160 - Depression, M2102d - Caregiver Performs Treatment, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, nausea/vomiting, limited strength, limited range of motion, swelling of affected area, Pain Effect on Sleep, Pain Interference with ADLs, Pain Interference with Therapy activities, balance deficit, loss of appetite, #1 - Non-Observable Surgical Wound - Anterior Left Below Knee - , swell/redness surround. skin, red/tender pressure points

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Below Knee -: 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., cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, train caregiver(s) to perform medical/rehabilitation treatments, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

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

SN Goals

PATIENT-STATED GOAL: To walk without 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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* 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

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

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/05/2026

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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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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 is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (06/05/26-06/06/26) ,WK2: 3 (06/07/26-06/13/26) ,WK3: 2 (06/14/26-06/20/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170P1 - Picking Up Object, 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, GG0170G1 - Car Transfer, GG0170D1 - Sit to Stand, 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, GG0170F1 - Toilet Transfer

PROCEDURES: Stretching to left knee. Original ROM 0-65: Stretching to left knee 5x hold 10 seconds, home exercise program: Sitting knee extension, ankle pumps. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Supine quad sets, short arc quads, hip flexion, straight leg raise, hip abduction, equipment training, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: 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 - 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, Car Transfer - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: Be able to get around with my cane again.

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

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

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

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

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 - 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

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Upper Body Dressing - 06. Independent

Car Transfer - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/05/2026