Home Health Certification and Plan of Care

Order ID: 1150/19682

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
011068403	06/11/2026	From: 06/11/2026 To: 08/09/2026	24298	217058

6. Patient's Name and Address

Frances James
12 Judywood Ln,
Baltimore, MD 21221-
443-554-0675

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 09/01/1954 **9.Sex** Female

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

13. ICD	Other Pertinent Diagnoses	Date
Z96.653	Presence of artificial knee joint bilateral	06/11/26
I70.0	Atherosclerosis of aorta	06/11/26
E03.9	Hypothyroidism unspecified	06/11/26
M85.80	Oth disrd of bone density and structure unspecified site	06/11/26
M54.50	Low back pain unspecified	06/11/26
G89.29	Other chronic pain	06/11/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/11/26
Z79.82	Long term (current) use of aspirin	06/11/26
Z86.16	Personal history of COVID-19	06/11/26

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

Ibuprofen - Ibuprofen 600 mg take 1 tablet by mouth every 8 hours
Extra Strength Tylenol - Acetaminophen 500 mg, 2 tablet by mouth every 6 hours
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, 1 tablet by mouth every 4 hours As needed for pain
Colace - Docusate Sodium 100 mg , Take 1 capsule by mouth twice a day Constipation
LIPITOR tablet Oral daily For cholesterol and heart protection
LEVOTHYROXINE 1 TABLET Oral DAILY 30 MINS BEFORE BREAKFAST
FOSAMAX tablet Oral once a week Take 1 tablet by mouth once a week on the same day in the morning with 6-8 ounces of water at least 30 minutes before the first food, drink or other medication of the day. Do not lie down for at least 30 minutes after swallowing this medication
CALCIUM tablet Oral 3 times a day with meals
glucosamine/chondr sulf-A sod (GLUCOSAMINE-CHONDROITIN) 750-600 mg Oral Tab tablet Oral once a day Take 1 tablet by mouth

14. DME and Supplies:

walker, bath bench

15. Safety Measures:

walker precautions, standard precautions, medication safety, fall precautions, , ambulates with device, ,

16. Nutrition:

regular

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: 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: 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:

The patient is a 71-year-old female admitted to home health services following an elective left total knee replacement secondary to advanced osteoarthritis. Her past medical history is significant for hypothyroidism, atherosclerosis of the aorta, chronic low back pain, gastroesophageal reflux disease (GERD), osteoarthritis, and other disorders of bone density and structure. The patient is well known to physical therapy from prior treatment episodes and recently underwent a right total knee replacement before the current left knee procedure. She returned home on the day of surgery and resides with her husband, who serves as her primary caregiver. The patient lives in a mobile home with five steps to enter, equipped with a handrail for safety. During the skilled nursing assessment, the patient was alert and oriented to person, place, time, and situation. She denied shortness of breath, dizziness, lightheadedness, or other acute complaints. Although she reported no significant pain during the nursing visit, physical therapy assessment identified postoperative left knee pain consistent with the recent surgical procedure. The left knee surgical incision was covered with an Aquacel dressing that was clean, dry, and intact. Per physician orders, the dressing is scheduled to be removed on postoperative day seven, after which the incision will be left open to air. The patient was observed wearing prescribed compression stockings. Medication reconciliation was completed, and education was provided regarding medication compliance, postoperative recovery expectations, ice therapy, constipation prevention, and monitoring for signs and symptoms of infection or other complications. The patient demonstrated understanding of all instructions provided. Prior to surgery, the patient was independent with ambulation without an assistive device, transfers, and activities of daily living. Since undergoing left total knee replacement, she has experienced a decline in functional mobility. Physical therapy evaluation revealed left knee pain, decreased left knee range of motion, lower extremity weakness, impaired balance, gait dysfunction, and deficits with bed mobility and transfers. Balance assessment yielded a Tinetti score of 8/28, indicating a high risk for falls. The patient currently ambulates with a walker and requires skilled instruction to safely perform mobility tasks and adhere to postoperative precautions. Skilled physical therapy interventions focused on gait training with emphasis on proper sequencing and safe walker use. Instruction was provided regarding promotion of left knee flexion and extension during the swing phase of gait to improve gait mechanics and functional mobility. The patient also received education and training on safe transfer techniques, including proper hand placement and body mechanics to reduce fall risk and maximize independence. Therapeutic exercises were initiated to improve left knee range of motion, increase lower extremity strength, and support postoperative recovery. Additional education was provided regarding the use of ice therapy, with instructions to apply ice for 20 minutes on and 20 minutes off as needed to assist with pain and edema management. The patient was also instructed to sleep in a supine position and focus on maintaining knee extension while resting to prevent flexion contractures and promote optimal range-of-motion outcomes. Written handouts outlining prescribed supine and seated therapeutic exercises were provided, and both the patient and her husband verbalized understanding of the exercise program and treatment recommendations. The patient remains temporarily homebound due to postoperative pain, impaired balance, lower extremity weakness, decreased knee range of motion, gait dysfunction, and the need for an assistive device for safe ambulation. Skilled nursing services are medically necessary for ongoing postoperative assessment, incision monitoring, medication management, and reinforcement of patient education. Skilled physical therapy services are medically necessary to address deficits in strength, balance, range of motion, transfers, gait, and overall functional mobility. The plan of care focuses on improving left knee mobility, restoring strength and endurance, enhancing safety with ambulation and transfers, reducing fall risk, and facilitating the patient's return to her prior level of function and independence within the home and community.
 Date of Order 06/11/2026 Orders Physician Face-to-Face Date: 06/01/2026 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 <span style="font-size:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/11/2026

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 : 06/01/2026

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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14px;">
 Physician Narcisse, Patrick

SN Careplans

SN WK1: 1 (06/11/26-06/13/26) ,WK2: 1 (06/14/26-06/20/26)

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, abn cholesterol > 200 mg/dL, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, balance deficit, Pain Interference with ADLs, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Left Knee -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee -: Left knee surgical site: Remove Aquacel dressing on the 7th day post op and LOTA, otherwise, cover with a dry gauze if drainage occurs., 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 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

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
* 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
* 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

PT Careplans

PT WK1: 1 (06/11/26-06/13/26) ,WK2: 3 (06/14/26-06/20/26) ,WK3: 2 (06/21/26-06/27/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, 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,

PT Goals

PATIENT-STATED GOAL: To be independent again walk with nothing and get out easily

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/11/2026

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GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Medication management : Review medication with pt and caregiver, Range of motion : Improve L knee flexion progress to 95 to 100 degrees amd extension to 0 degrees, cough/deep breathing exercises, home exercise program: Supine SLR, QS, seated laq, hip flexion, heelraises, toe raises, seated heelslides lle 20 second holds, 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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, Picking Up Object - 05. Setup or clean-up 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, Range of motion

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

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

Car Transfer - 06. Independent

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

4 Steps - 05. Setup or clean-up assistance

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Range of motion

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

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

Shower/Bathe Self - 03. Partial/moderate assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/11/2026