Home Health Certification and Plan of Care

Order ID: 1150/19668

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
99304480	06/11/2026	From: 06/11/2026 To: 08/09/2026	26142	217058

6. Patient's Name and Address

Alice Clifton
6106 Bertram Ave,
Baltimore, MD 21214-
443-769-0866

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 06/02/1953 **9.Sex** Female

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

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	06/11/26
M17.12	Unilateral primary osteoarthritis left knee	06/11/26
I10.	Essential (primary) hypertension	06/11/26
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	06/11/26
E11.65	Type 2 diabetes mellitus with hyperglycemia	06/11/26
D64.9	Anemia unspecified	06/11/26
E11.69	Type 2 diabetes mellitus with other specified complication	06/11/26
E78.5	Hyperlipidemia unspecified	06/11/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	06/11/26
Z79.51	Long term (current) use of inhaled steroids	06/11/26
Z86.0100	Personal history of colonic polyps	06/11/26
Z90.710	Acquired absence of both cervix and uterus	06/11/26

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

COLACE 100 mg / 1 Capsule by mouth 2 times a day
MOTRIN 600 mg / 1 Tablet by mouth as necessary every 6 hours. Take with food.
LIPITOR 40 mg / 1 Tablet by mouth daily at bedtime
HYZAAR 50-12.5 mg / 1 Tablet by mouth daily
CARAFATE 1 gm / 1 Tablet by mouth 2 times daily Dissolve 1 tablet in 15 mL of water take before meals. (Patient not taking: Reported on 5/29/2026)
TYLENOL 500 mg/tablet / Take 2 tablets by mouth every 8 hours as needed for pain
ECOTRIN Delayed Release 81 mg / 1 Tablet by mouth twice a day
Roxicodone - Oxycodone Hydrochloride 5 mg/tablet / Take 1-2 tablets by mouth every 4 hours as needed for pain
Famotidine - Famotidine 20 mg 20mg=1tablet by mouth twice a day
Humulin R - Insulin Recombinant Human 0-12 Units subcutaneous TID with meals

14. DME and Supplies:

walker, hand held shower, diabetic supplies, bath bench

15. Safety Measures:

standard precautions, fall precautions, diabetic precautions, knee precautions, medication safety, walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with assistance, ambulates with device

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Transfer bed/Chair, Walker, Exercises Prescribed, 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: 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 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 72-year-old female admitted to home health services following a recent right total knee replacement. Her past medical history is significant for osteoarthritis, type 2 diabetes mellitus, hypertension, hyperlipidemia, and anemia. Skilled nursing admission was completed, and the patient was found to be alert and oriented with vital signs within normal limits. A comprehensive assessment was performed, including evaluation of the surgical site, medication review, and patient education. The patient resides with her spouse in a single-family home, where her husband is available and willing to assist with care and support as needed throughout her recovery. Assessment of the right knee surgical site revealed the postoperative dressing to be clean, dry, and intact with no visible signs of infection, drainage, dehiscence, or other complications. The patient reported postoperative discomfort consistent with her recent surgical procedure but denied any acute concerns. Skilled nursing education was provided regarding pain management, including adherence to the prescribed pain medication regimen, proper timing of medications, and the use of non-pharmacological comfort measures such as positioning, rest, activity pacing, and cold therapy as appropriate. The patient demonstrated understanding of the instructions provided. Given the patient's history of type 2 diabetes mellitus, comprehensive diabetic education was completed. Instruction included blood glucose monitoring techniques, recognition and management of signs and symptoms of hypoglycemia and hyperglycemia, adherence to dietary recommendations, and proper administration of sliding-scale insulin. Additional education focused on medication compliance, disease process management, and the importance of maintaining glycemic control to promote wound healing and reduce the risk of postoperative complications. The patient was also identified as being at increased risk for falls due to recent surgery, impaired mobility, and decreased lower extremity strength. Fall prevention education was provided, including maintaining a clutter-free environment, ensuring adequate lighting, wearing appropriate footwear, and utilizing prescribed assistive devices during ambulation and transfers. The patient was instructed on the proper and safe use of her rolling walker and other mobility aids to reduce the risk of injury and enhance independence. Physical therapy evaluation revealed significant functional limitations related to the recent right total knee replacement. The patient lives in a single-family home with 11 steps to enter but currently sleeps on the first floor to avoid stair negotiation. She ambulates approximately 30 feet on indoor surfaces using a rolling walker with supervision and requires supervision for bed mobility and transfers to and from a sofa, commode, and chair. The patient demonstrates decreased right knee range of motion measured at 5 to 75 degrees and impaired balance, as evidenced by a Tinetti Assessment score of 11/28, indicating a high risk for falls and supporting her homebound status due to the considerable and taxing effort required to leave the home safely. During the therapy evaluation, the patient tolerated therapeutic exercises including supine hip flexion, quadriceps sets, short arc quadriceps exercises, straight leg raises, hip abduction exercises, seated knee extensions, and ankle pumps. Skilled physical therapy is medically necessary to address deficits in strength, range of motion, balance, gait, transfers, endurance, and overall functional mobility. The goal of treatment is to improve right knee mobility, increase lower extremity strength, restore functional independence, reduce fall risk, and facilitate a safe return to her prior level of function. The plan of care includes ongoing skilled nursing services for postoperative assessment, surgical site monitoring, medication management, diabetic education, disease process management, and reinforcement of patient and caregiver teaching. Skilled physical therapy services will continue to focus on therapeutic exercise, gait training, balance retraining, transfer training, range-of-motion improvement, and functional mobility progression. The patient and caregiver verbalized understanding of all education

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 : 05/29/2026

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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provided and are agreeable to the established plan of care.
 Date of Order 06/11/2026 Orders Physician Face-to-Face Date: 05/29/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right 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 (06/11/26-06/13/26) ,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: 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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2020 - Oral Med Management, meal preparation, A1250 - Lack of Necessary Transportation, M2102f - Patient Supervision, M1400 - Dyspnea, swelling in legs/around eyes, abnormal BS < 70/140 > mg/dL, muscle weakness, limited strength, limited endurance, limited range of motion, B1000 - Vision Deficit, Pain Interference with ADLs, Pain Effect on Sleep, balance deficit, #1 - Non-Observable Surgical Wound - Other - Right knee -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Right knee -, cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired

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, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient is adequately supervised, meal preparation is available to

SN Goals

PATIENT-STATED GOAL: Patient stated she would like to heal properly from surgery without difficulty

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/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 keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

patient's transportation needs are met

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

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

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patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

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

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, 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, GG0170G1 - Car 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, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Stretching to right knee 5x. Initially 5-75: Flexion and extension, home exercise program: Supine quad sets, short arc quads, hip flexion, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, ankle pumps. Sitting knee extension, ankle pumps, equipment training, gait training on uneven surfaces, gait training/stair training, transfers training

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, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet 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, 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 - 06. Independent, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: Walking by myself with a cane and not have pain.

GOALS
Toilet Transfer - 06. Independent

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

1 - Step (curb) - 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

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

Car Transfer - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

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

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

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

Oral Hygiene - 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	06/11/2026