Home Health Certification and Plan of Care

Order ID: 1150/20088

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
17227196	06/26/2026	From: 06/26/2026 To: 08/24/2026	26786	217058

6. Patient's Name and Address

Lucy Guerrero
101 Belfast Rd,
LUTHERVILLE TIMONIUM, MD 21093-
410-308-4973

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 01/04/1947 **9.Sex** Female

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

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	06/26/26
I10.	Essential (primary) hypertension	06/26/26
F33.9	Major depressive disorder recurrent unspecified	06/26/26
E78.00	Pure hypercholesterolemia unspecified	06/26/26
M85.80	Oth disrd of bone density and structure unspecified site	06/26/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/26/26
M54.12	Radiculopathy cervical region	06/26/26
M75.41	Impingement syndrome of right shoulder	06/26/26
M75.42	Impingement syndrome of left shoulder	06/26/26
M79.7	Fibromyalgia	06/26/26
I70.0	Atherosclerosis of aorta	06/26/26
M19.012	Primary osteoarthritis left shoulder	06/26/26
M47.814	Spondylosis w/o myelopathy or radiculopathy thoracic region	06/26/26
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	06/26/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	06/26/26
M54.16	Radiculopathy lumbar region	06/26/26
R73.03	Prediabetes	06/26/26
E66.9	Obesity unspecified	06/26/26
Z68.31	Body mass index [BMI] 31.0-31.9 adult	06/26/26
Z86.018	Personal history of other benign neoplasm	06/26/26
Z86.0101	Personal history of adeno	06/26/26
Z79.82	Long term (current) use of aspirin	06/26/26
Z79.1	Long term (current) use of non-steroidal non-inflam (NSAID)	06/26/26
Z79.891	Long term (current) use of opiate analgesic	06/26/26

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

DULCOLAX DR 5 mg/tablet / Take 2 tablets by mouth one time with at least 8 ounces of water at 12 noon the day before procedure
NORVASC 10 MG / 1 Tablet by mouth daily
PROZAC 40 MG / 1 Capsule by mouth in the morning
CRESTOR 10 MG / 1 Tablet by mouth daily to prevent heart attack and stroke

ZYRTEC 10 MG Tablet by mouth daily
Aspirin - Aspirin 81mg=1tablet by mouth twice a day
Oxaydo - Oxycodone Hydrochloride 5mg=1tablet by mouth every 4 hours As needed for pain
Meloxicam - Meloxicam 15 mg 1 tablet by mouth once a day Pain
Losartan Potassium - Losartan Potassium 25 mg 2 tablets by mouth once a day HTN
TYLENOL 500 mg/tablet / Take 1,000 mg by mouth every 6 hours As needed for pain
ATROVENT 21 mcg (0.03 %) Nasl Spray / Use 2 sprays in each nostril Nasal 3 times a day

14. DME and Supplies:

walker, hand held shower, bath bench

15. Safety Measures:

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

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

codeine oxycodone benadryl erythromycin bactrim hctz hmg inhibitors macrolid

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Transfer bed/Chair, Exercises Prescribed, 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: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

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

family/caregiver will be responsible for managing treatment

Homebound status: After undergoing Left 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 female admitted to home health services following a recent left total knee arthroplasty performed secondary to advanced degenerative joint disease/osteoarthritis. Her past medical history is significant for osteoarthritis, gastroesophageal reflux disease (GERD), major depressive disorder, prediabetes, hyperlipidemia, obstructive sleep apnea, hypertension, fibromyalgia, and a history of COVID-19. A comprehensive skilled nursing assessment was completed. The patient was alert and oriented, with vital signs within normal limits. Assessment of the surgical site revealed the left knee dressing to be clean, dry, intact, and securely in place without evidence of drainage, bleeding, erythema, or other signs of infection. Postoperatively, the patient presents with expected pain, left lower extremity weakness, impaired balance, decreased left knee range of motion, and reduced activity tolerance, resulting in significant limitations in functional mobility. She demonstrates difficulty with bed mobility, requiring increased time and assistance for positioning, impaired sit-to-stand transfers requiring upper extremity support and guarding for safety, and limited household ambulation due to an antalgic gait pattern, decreased weight-bearing tolerance through the left lower extremity, and reliance on an assistive device. Reduced endurance further limits her ability to safely negotiate stairs and perform routine functional mobility within the home. These deficits place the patient at an increased risk for falls and support her homebound status, as leaving the home requires considerable and taxing effort. Skilled nursing education focused on postoperative recovery and complication prevention. The patient was instructed on

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/26/2026

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 : 06/12/2026

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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appropriate pain management, including taking prescribed medications as directed, utilizing non-pharmacological pain relief measures, and promptly reporting uncontrolled or worsening pain to the healthcare provider. Education was also provided regarding postoperative swelling management through elevation of the affected extremity, application of ice as prescribed, use of compression garments if ordered, and completion of provider-approved therapeutic exercises. Additional teaching included recognition of signs and symptoms of surgical site infection, medication adherence, fall prevention strategies, safe use of assistive devices, maintenance of adequate hydration and nutrition to promote wound healing, and the importance of attending all scheduled follow-up appointments with the orthopedic surgeon. The patient verbalized understanding of all education provided. Skilled home health physical therapy is medically necessary to address postoperative impairments through therapeutic exercises to improve lower extremity strength and knee range of motion, gait training, transfer training, balance training, pain management strategies, endurance training, stair negotiation, and safety education. Continued skilled nursing services are also indicated for ongoing assessment of the patient's postoperative status, monitoring of the surgical incision, pain and medication management, reinforcement of education, and surveillance for signs of infection or other postoperative complications. The overall goal of care is to promote safe recovery, restore functional independence, reduce fall risk, prevent complications and rehospitalization, and facilitate the patient's return to her prior level of function.
 Date of Order 06/26/2026 Orders Physician Face-to-Face Date: 06/12/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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 WK1: 1 (06/26/26-06/27/26) ,WK2: 1 (06/28/26-07/04/26)

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: 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 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: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, M1400 - Dyspnea, limited strength, limited endurance, limited range of motion, swelling of affected area, B1000 - Vision Deficit, Pain Interference with ADLs, Pain Effect on Sleep, balance deficit, #1 - Non-Observable Surgical Wound -

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
* 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
* 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
* 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	06/26/2026

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interference with ADLs, Pain Effect on Sleep, balance deficit, #1 - Non-Observable Surgical Wound Anterior Left Knee - , swell/redness surround. skin

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee -, cough/deep breathing exercises, incentive spirometer, 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, * 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, * 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 patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (06/26/26-06/27/26) ,WK2: 2 (06/28/26-07/04/26) ,WK3: 3 (07/05/26-07/11/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170O1 - 12 Steps, 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, GG0170D1 - Sit to Stand, 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

PROCEDURES: B LE mm 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

TEACH PATIENT/CAREGIVER: 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

PT Goals

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

GOALS

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/26/2026