Home Health Certification and Plan of Care

Order ID: 1150/12073

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
131282918	09/09/2025	From: 09/09/2025 To: 11/07/2025	16559	217058

6. Patient's Name and Address

Mary Stuller
302 Gailridge Rd,
Timonium, MD 21093-
410-252-8926

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 04/13/1947 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	09/09/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	09/09/25
E11.9	Type 2 diabetes mellitus without complications	09/09/25
M81.0	Age-related osteoporosis w/o current pathological fracture	09/09/25
M85.80	Oth disrd of bone density and structure unspecified site	09/09/25
E78.5	Hyperlipidemia unspecified	09/09/25
E21.3	Hyperparathyroidism unspecified	09/09/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	09/09/25
Z96.1	Presence of intraocular lens	09/09/25
Z87.442	Personal history of urinary calculi	09/09/25

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

Asa 81 Mg - Aspirin 81mg; 1 tab by mouth twice a day post op anticoagulant
Vitamin D-3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25mcg; 1000 IU 4 TABS by mouth once a day BONE HEALTH
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25 mcg (1,000 unit), Take 4 tablets by mouth once a day BONE HEALTH
Colace - Docusate Sodium 100MG; 1 CAP by mouth twice a day BOWEL REGIMEN
Folic Acid - Folic Acid 1 mg, Take 1 tablet by mouth once a day SUPPLEMENT
Glucotrol Xl - Glipizide 2.5 mg 2.5 mg, Take 1 tablet by mouth in the morning Take 1 tablet by mouth every morning with a meal DM
Hydrodiuril - Hydrochlorothiazide 25 mg 25 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily HTN
Lopressor - Metoprolol Tartrate 25 mg, Take onehalf tablet by mouth twice a day HTN
Crestor - Rosuvastatin Calcium 10 mg 10 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily to prevent heart attack and stroke
Ondansetron - Ondansetron 4 mg 4MG; 1 TAB sublingual every 8 hours AS NEEDED FOR NAUSEA
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5MG; 1-2 TABS by mouth every 4 hours AS NEEDED FOR PAIN
Vigamox - Moxifloxacin Hydrochloride 0.5 % Opht Drop, Instill 1 Drop left eye four times a day Instill 1 Drop in left eye 4 times a day starting 2 days before surgery and after surgery as directed

14. DME and Supplies:

walker, cane, ice man

15. Safety Measures:

medication safety, knee precautions, infectious material management, standard precautions, diabetic precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, transfer with assist, anticoagulant precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Walker, Exercises Prescribed

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:

22.B.Discharge Plans

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 09/09/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

James Huang
8028 Ritchie Hwy
Pasadena, MD 21122
PHONE: 410-737-5600 FAX: 14107375391 NPI: 1154567709

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 : 08/28/2025

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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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.

patient will be responsible for managing treatment

Homebound status: After undergoing Right Total Knee Replacement surgery, 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:

Start of care was completed for a 78-year-old female with a history of pseudophakia, hypertension, ovarian cancer, osteoporosis, type 2 diabetes mellitus, hyperparathyroidism, hyperlipidemia, and vitamin D deficiency. The patient is recovering from a right total knee replacement and is receiving assistance from her spouse for all ADLs and IADLs. She is alert and oriented to person, place, and time, reports right knee pain at a level of 5/10, and is managing pain with oxycodone and ice therapy. Surgical dressing on the right knee is intact, with scant old bloody drainage noted. She denies shortness of breath and lung sounds are clear. The patient is using a rolling walker for ambulation and demonstrates safety awareness with mobility. Skilled nursing services are being provided at a frequency of 1W2, with physical therapy evaluation and treatment initiated. Physical therapy assessment revealed limitations in endurance, dynamic standing balance, strength, range of motion, and overall functional mobility. The patient performs transfers and ambulation with supervision to contact guard assistance, using a rolling walker with an antalgic gait and step-to pattern. Right knee range of motion is measured at 8 to 100 degrees with overpressure. A Timed Up and Go (TUG) test was completed in 33 seconds, indicating a high risk for falls. A home exercise program (HEP) was reviewed, including supine exercises, sit-to-stands, and hourly ambulation. The patient was educated on effective pain management, including taking medication prior to therapy sessions, and was receptive to all instructions. She also reported no current bowel movement and is taking docusate sodium for support. The patient will benefit from continued skilled therapy services to improve strength, mobility, and safety, and to support a return to her prior level of function.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 09/09/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 08/28/2025
 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat dx: Right Total Knee Replacement Surgery
 Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval Notes: <o:p></o:p> Physician: Huang, James

SN Careplans

SN WK1: 1 (09/09/25-09/13/25) ,WK2: 1 (09/14/25-09/20/25)

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

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.

right knee
Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited endurance, limited strength, limited range of motion, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, bruising/discoloration, #1 - Non-Observable Surgical Wound - Anterior Right Knee - old bloody drainage note on dressing

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , Discharge Summary: Please complete the Discharge Summary SN communication note. , cough/deep breathing

SN Goals

PATIENT-STATED GOAL: To walk better and not get a blood clot

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
* diet
* weight-bearing exercises to promote bone healing and strengthening
* fluids to prevent constipation
* home safety
* pain control
* 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
* 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

meal preparation is available to patient for all meals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles SN RN

Date

09/09/2025

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exercises, incentive spirometer, physician-ordered wound care: 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.

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, * diet weight-bearing exercises to promote bone healing and strengthening fluids to prevent constipation home safety pain control, 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, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 2 (09/09/25-09/13/25) ,WK2: 3 (09/14/25-09/20/25) ,WK3: 1 (09/21/25-09/27/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Interference with Therapy activities, GG0170I1 - Walk 10 Feet, GG0130A1 - Eating, 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, GG0130B1 - Oral Hygiene, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing

PROCEDURES: Therapeutic exercise , Dynamic standing balance , Medication Review-Medications reviewed with patient/caregiver., 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, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Sit to Stand - 06. Independent, Chair to Bed to Chair - 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, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Medication Review-Patient/caregiver, related purpose and schedule of medications.

PT Goals

PATIENT-STATED GOAL: To walk independently

GOALS
Chair to Bed to Chair - 06. Independent

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

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

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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Sit to Stand - 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

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

Oral Hygiene - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Toileting Hygiene - 06. Independent

Medication Review- Patient/caregiver recalls related purpose and schedule of medications.

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/09/2025