Home Health Certification and Plan of Care

Order ID: 1150/12504

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
44606184100	09/17/2025	From: 09/17/2025 To: 11/15/2025	5045	217058

6. Patient's Name and Address

Monica Floyd
107 N Carey St,
BALTIMORE, MD 21223-
443-857-3992

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 05/21/1964 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	09/17/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	09/17/25
I10.	Essential (primary) hypertension	09/17/25
N60.81	Other benign mammary dysplasias of right breast	09/17/25
N87.9	Dysplasia of cervix uteri unspecified	09/17/25
E78.00	Pure hypercholesterolemia unspecified	09/17/25
F33.9	Major depressive disorder recurrent unspecified	09/17/25
R91.8	Other nonspecific abnormal finding of lung field	09/17/25
E66.9	Obesity unspecified	09/17/25
Z68.30	Body mass index [BMI] 30.0-30.9 adult	09/17/25
Z87.891	Personal history of nicotine dependence	09/17/25
Z79.891	Long term (current) use of opiate analgesic	09/17/25

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

Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 6 hours For pain as needed
Norvasc - Amlodipine Besylate eq 2.5 mg base 2.5mg; 1 tab by mouth once a day blood pressure
Asa 81 Mg - Aspirin 81mg; 1 tab by mouth twice a day post right knee TKR
Tenormin - Atenolol 25 mg 25 mg oral tab , take 1 tablet by mouth once a day HTN
Lipitor - Atorvastatin Calcium eq 40 mg base 40 mg oral tab , take 1 tablet by mouth once a day For cholesterol and heart protection
Cholecalciferol, Vitamin D3, (VITAMIN D3) 25mcg(1000 unit) oral capsule, take 3 capsule by mouth once a day BONE HEALTH
Colace - Docusate Sodium 100mg; 1 CAP by mouth twice a day 2 tab for constipation
Cymbalta - Duloxetine Hydrochloride 20 mg 20mg oral cpdr sr cap , take 2 capsule by mouth once a day DEPRESSION
Esidrix - Hydrochlorothiazide 25 mg 25mg oral tab, take 1 tablet by mouth once a day HTN
Meloxicam - Meloxicam 15 mg 15MG; 1TAB by mouth once a day PAIN
Tylenol - Acetaminophen 500 mg oral tab , take 2 tablets by mouth every 8 hours As needed for pain

14. DME and Supplies:

walker, cane

15. Safety Measures:

bathroom safety, infectious material management, , knee precautions, , , ambulates with device, walker precautions, ,

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

Lisinopril

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: 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 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:

The patient is a 61-year-old female, status post right total knee replacement (TKR), with a past medical history significant for right breast cancer, severe obesity, right knee osteoarthritis, uterine fibroids, hypertension, hypercholesterolemia, and prior left total hip replacement. Start of care (SOC) was completed today. Skilled nursing frequency is planned at one visit every two weeks (1W2), and a physical therapy evaluation has been ordered. The patient resides with her sister in a first-floor apartment with three steps and a railing at the entrance; her sister assists with all ADLs and IADLs as needed. The patient is alert and oriented 3, reporting right knee pain at 4/10. Her last dose of oxycodone was at 8:30 AM, and acetaminophen was taken at 10:20 AM. She denies shortness of breath, and lung sounds are clear throughout. Appetite is reported as good, and her last bowel movement occurred prior to surgery. Right knee dressing demonstrates scant bloody drainage without signs of infection. The patient ambulates safely with a rolling walker for 30 feet indoors under supervision, requiring cues for appropriate gait pattern. Transfers to the toilet, bed, and sofa are performed with supervision. Current right knee range of motion is measured at 5-85 degrees. She is able to tolerate 10 repetitions of therapeutic exercises, including quadriceps sets, short arc quadriceps, straight leg raises, hip abduction, hip flexion, knee extension, and ankle pumps. Tinetti score is 14/28, confirming significant fall risk and homebound status, as leaving the home requires considerable effort. Skilled nursing services included review of all medications, dosages, frequencies, and pertinent side effects. Patient and sister were instructed on effective pain management strategies and post-operative discharge instructions, with both demonstrating receptiveness. The patient will benefit from ongoing skilled therapy services to improve right knee strength, range of motion, mobility, and safety with ambulation, ultimately supporting her progression toward greater independence in functional mobility and ADLs.
 Date of Order 09/17/2025 Orders Physician Face-to-Face Date: 08/27/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to 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
 1 - SOC - SN Notes: soc PT Eval Notes: eval Physician Huang , James

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 09/17/2025

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 : 08/27/2025

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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SN WK1: 1 (09/17/25-09/20/25) ,WK2: 1 (09/21/25-09/27/25)

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, 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; 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited range of motion, swelling of affected area, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Right Knee - DRESSING INTACT WITH SCANT AMOUNT OF BLOODY DRAINAGE NOTED

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , Discharge Summary- Complete Discharge Summary SN communication note. , cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: TO RIGHT KNEE SURGICAL SITE- 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, * 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, * 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

PATIENT-STATED GOAL: TO WALK BETTER

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
* 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

PT Careplans	PT Goals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/17/2025

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PT WK1: 2 (09/17/25-09/20/25) ,WK2: 3 (09/21/25-09/27/25) ,WK3: 1 (09/28/25-10/04/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Effect on Sleep, 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: Home exercise program : Supine hip flexion, hip abduction, straight leg raise, short Arc quads, quad sets. Sitting knee extension, ankle pumps. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats , Stretching to right knee, Medication Review- : Medications reviewed with patient/caregiver. , 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, 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 - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 06. Independent, Car Transfer - 04. Supervision or touching 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, ROM RIGHT KNEE 0 TO 100 DEGREES

PATIENT-STATED GOAL: Ambulate independently with cane on all surfaces

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

Lower Body Dressing - 06. Independent

ROM RIGHT KNEE 0 TO 100 DEGREES

Shower/Bathe Self - 03. Partial/moderate assistance

Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

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

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

Don/Doff Footwear - 06. Independent

Car Transfer - 04. Supervision or touching assistance

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

4 Steps - 05. Setup or clean-up 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

12 Steps - 05. Setup or clean-up assistance

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/17/2025