# Home Health Certification and Plan of Care

**Order ID: 1150/12669**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 36308521 | 09/19/2025 | From: 09/19/2025 To: 11/16/2025 | 17043 | 217058 |

**6. Patient's Name and Address**

Tracy Brown
2525 Riggs Ave,
BALTIMORE, MD 21216-
443-447-4933

**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** 10/17/1956 **9.Sex** Female

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| Z47.1 | Aftercare following joint replacement surgery | 09/19/25 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| Z96.651 | Presence of right artificial knee joint | 09/19/25 |
| I13.10 | Hyp hrt & chr kdny dis w/o hrt fail w stg 1-4/unsp chr kdny | 09/19/25 |
| N18.31 | Chronic kidney disease stage 3a | 09/19/25 |
| M19.011 | Primary osteoarthritis right shoulder | 09/19/25 |
| M17.12 | Unilateral primary osteoarthritis left knee | 09/19/25 |
| I48.0 | Paroxysmal atrial fibrillation | 09/19/25 |
| D68.69 | Other thrombophilia | 09/19/25 |
| K76.0 | Fatty (change of) liver not elsewhere classified | 09/19/25 |
| M54.12 | Radiculopathy cervical region | 09/19/25 |
| K21.9 | Gastro-esophageal reflux disease without esophagitis | 09/19/25 |
| G47.00 | Insomnia unspecified | 09/19/25 |
| Z79.01 | Long term (current) use of anticoagulants | 09/19/25 |
| Z90.710 | Acquired absence of both cervix and uterus | 09/19/25 |
| Z86.73 | Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits | 09/19/25 |

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

Catapres - Clonidine Hydrochloride 0.2 mg Oral Tab,take 1/2 tablet by mouth once a day Take half tablet by mouth daily
Warfarin - Warfarin Sodium 5 mg Oral Tab by mouth as necessary Take as directed by Anticoagulation Clinic (888-845-0095)
Naloxone (NARCAN) ) 4 mg/actuation Nasl Spray nasal cannula as necessary Spray in 1 nostril if not breathing/responding. Call 911. If still not breathing/responding, use new spray in 2 to 3 minutes in other nostril. For suspected opioid overdose use only
Albuterol (PROAIR/PROVENTIL/VENTOLIN) 90 mcg/Inhale 1 Puff inhalant every 4 hours Inhale 1 Puff by mouth every 4 hours as needed (rescue inhaler)
oxyCODONE-Acetaminophen (PERCOCET) Take 10-325 tablets by mouth every 8 hours Take 10-325 tablets by mouth every 8 hours as needed
Mirtazapine - Mirtazapine 15 mg by mouth at bedtime
Extra Strength Tylenol - Acetaminophen 500mg 2TABLET by mouth three times a day FOR PAIN

**14. DME and Supplies:**

walker, hand held shower, bath bench, cane

**15. Safety Measures:**

walker precautions, restricted ROM, , knee precautions, infectious material management, , cardiac precautions, , bathroom safety, avoid temperature extremes, , ambulates with device

**16. Nutrition:**

low sodium

**17. Allergies:**

NSAIDs

**18.A. Functional Limitations**

Dyspnea With Minimal Exertion, Ambulation, Endurance

**18.B. Activities Permitted**

Walker, Cane, Up As Tolerated

**19. Mental & Pyschosocial Status:** COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

**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 Right 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 68-year-old female with a medical history significant for osteoarthritis, hypertension, and a prior cerebrovascular accident. She recently underwent a right total knee replacement. During the visit, the patient was alert and oriented, denying chest pain, palpitations, or dizziness. She did report shortness of breath with minimal exertion. Lung sounds were clear to auscultation. Bowel and bladder functions were intact, with the last bowel movement reported the previous night and normoactive bowel sounds noted. The patient was able to void without complications. Pedal pulses were present bilaterally. The surgical dressing was intact, with the patient aware it would be removed seven days post-procedure.  Mobility <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh> revealed the patient ambulated 30 feet 2 indoors with a rolling walker under supervision, demonstrating a limping gait. She declined stair training. Bed mobility required moderate assistance, and transfers to bed, chair, and toilet were completed with supervision. Right knee range of motion was measured at 5-80 degrees. Functional mobility is significantly limited, and the patient is considered homebound due to the substantial effort required to leave the home, supported by a Tinetti score of 12/28.  Therapeutic exercises performed during the session included right leg quadriceps sets, short arc quadriceps, hip flexion, hip abduction, seated knee extension, and ankle pumps (10 repetitions each), with active-assisted straight leg raises and short arc quadriceps completed. The patient tolerated the session well.  Extensive education was provided to the patient and caregiver regarding medication actions and effects, recognition of deep vein thrombosis and infection symptoms, proper use of compression stockings, importance of elevation of the surgical leg above heart level, use of ice for 20 minutes several times daily, and safe medication adherence. The patient successfully demonstrated return use of the incentive spirometer. Both the patient and caregiver were receptive to education and verbalized understanding. <br> Date of Order 09/19/2025 Orders Physician Face-to-Face Date: 09/05/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right 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 <br> <span style="white-space: pre;

**23. Signature and Date of Verbal SOC Where Applicable:**

Electronically Signed by Messick, Charles SN RN on 09/19/2025

**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 : 09/05/2025

**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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white-space: normal;"> 1 - SOC - SN Notes: soc PT Eval Notes: eval <br> Physician Huang , James

## SN Careplans

SN WK1: 1 (09/19/25-09/20/25) ,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: 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, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, wheezing, dependent edema, abnormal blood pressure, heartburn/indigestion, swelling of affected area, muscle weakness, limited endurance, limited strength, Pain Interference with Therapy activities, B1000 - Vision Deficit, balance deficit, difficulty sleeping, Pain Interference with ADLs, Pain Effect on Sleep, loss of appetite, bruising/discoloration, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Knee -

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, 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., monitor intake & output, teach/coordinate/arrange medication packaging and/or administration

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * 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, * strict compliance with physician orders for anticoagulant administration avoiding activities that create unnecessary risk for injury monitoring for prolonged bleeding from cuts, blood in urine or stool, or unusual bruising for warfarin, limiting foods high in Vitamin K, such as leafy green vegetables, * lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings physical exercise plan diet, related medication(s) purpose, schedule, * lifestyle modification to manage blood condition including dietary changes bleeding precautions, 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 manage sleep disorder including changes to daytime habits and bedtime routine maintaining a journal to track

## SN Goals

PATIENT-STATED GOAL: I want 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 take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet
* exercise
* monitoring of blood pressure
* blood sugar
* home
* recalls related medication(s) purpose, schedule remedies

patient/caregiver recalls
* how to manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* dietary modifications for liver disorder
* 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
* low-fat diet
* lifestyle modifications to manage esophageal condition
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to manage sleep disorder including changes to daytime habits and bedtime routine
* maintaining a journal to track sleep patterns
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strict compliance with physician orders for anticoagulant administration
* avoiding activities that create unnecessary risk for injury
* monitoring for prolonged bleeding from cuts, blood in urine or stool, or unusual bruising
* for warfarin, limiting foods high in Vitamin K, such as leafy green vegetables

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 is adequately supervised

caregiver administers and/or packages medications appropriately

| Signature of Physician: | Date |
|---|---|
| | PAGE 2 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by Messick, Charles SN RN | 09/19/2025 |

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sleep patterns, related medication(s) purpose, schedule, * how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet exercise monitoring of blood pressure blood sugar home, related medication(s) purpose, schedule remedies, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * low-fat diet lifestyle modifications to manage esophageal condition, related medication(s) purpose, schedule, * dietary modifications for liver disorder, related medication(s) purpose, schedule, * how to manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, 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 is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage peripheral vascular condition including how to apply compression stockings
* physical exercise plan
* diet
* recalls related medication(s) purpose, schedule

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

## PT Careplans

PT WK1: 1 (09/19/25-09/20/25) ,WK2: 3 (09/21/25-09/27/25) ,WK3: 2 (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 : Quad sets, short Arc quads, hip flexion, hip abduction, straight leg raise. Standing knee flexion,hip abduction, plantarflexion, hip extension, squats. Sitting knee extension, ankle pumps , Stretching to right knee. Initially 5-80, 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., 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, Right knee 0-90

## PT Goals

PATIENT-STATED GOAL: Walk with a cane without pain

GOALS
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

Lower Body Dressing - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Don/Doff Footwear - 06. Independent

Car Transfer - 04. Supervision or touching assistance

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

12 Steps - 05. Setup or clean-up assistance

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

Right knee 0-90

Sit to Stand - 04. Supervision or touching assistance

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

Oral 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

Toileting Hygiene - 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

4 Steps - 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 | 09/19/2025 |