Home Health Certification and Plan of Care

Order ID: 1150/12766

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
35804675	09/29/2025	From: 09/29/2025 To: 11/26/2025	17820	217058

6. Patient's Name and Address

Anita Lane
1230 Needham Court,
CROFTON, MD 21114-
410-718-8562

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 07/24/1946 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	09/29/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	09/29/25
E87.5	Hyperkalemia	09/29/25
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	09/29/25
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	09/29/25
N18.32	Chronic kidney disease stage 3b	09/29/25
D50.0	Iron deficiency anemia secondary to blood loss (chronic)	09/29/25
E78.5	Hyperlipidemia unspecified	09/29/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	09/29/25
H40.9	Unspecified glaucoma	09/29/25
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	09/29/25
K59.04	Chronic idiopathic constipation	09/29/25
M15.9	Polyosteoarthritis unspecified	09/29/25
G56.03	Carpal tunnel syndrome bilateral upper limbs	09/29/25
M51.369	Oth intvrt disc degen lum rgn w/o lum bck or lw extrm painOth intvrt disc degen lum rgn w/o lum bck or lw extrm pain	09/29/25
N39.46	Mixed incontinence	09/29/25
E55.9	Vitamin D deficiency unspecified	09/29/25
Z79.82	Long term (current) use of aspirin	09/29/25
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	09/29/25
Z87.891	Personal history of nicotine dependence	09/29/25

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

Ecotrin - Aspirin 81 MG EC , Take 1 Tablet (81 mg total) by mouth twice a day Take 1 Tablet (81 mg total) by mouth 2 times daily For 6 weeks for DVT prophylaxis.
Robaxin - Methocarbamol 750 MG , Take 1 Tablet by mouth three times a day Take 1 Tablet (750 mg total) by mouth 3 times daily as needed for Muscle Spasms
Percocet - Acetaminophen: Oxycodone Hydrochloride 5-325 MG , Take 1 Tablet by mouth every 6 hours Take 1 Tablet by mouth every 6 Hours as needed for Pain
Moderate or Pain
Severe Max Dally
Amount: 4 Tablets As previously prescribed by your outpatient provider.
Tylenol - Acetaminophen 325 MG , Take 2 Tablets by mouth every 6 hours Take 2 Tablets (650 mg total) by mouth every 6 Hours as needed for Pain
Norvasc - Amlodipine Besylate 10 MG , Take 1 Tablet by mouth once a day Take 1 Tablet (10 mg total) by mouth daily
Lipitor - Atorvastatin Calcium 40 MG , Take 1 Tablet by mouth once a day Take 1 Tablet (40 mg total) by mouth daily
Catapres - Chlorthalidone: Clonidine Hydrochloride 0.1 MG , Take 1 Tablet by mouth in the morning Take 1 Tablet (0.1 mg total) by mouth daily in the morning
Tricor - Fenofibrate 48 MG , Take 1 Tablet by mouth once a day Take 1 Tablet (48 mg total) by mouth daily
Xalatan - Latanoprost 0.005% , Place 1 Drop into both eyes (eye drops) both eyes at bedtime Place 1 Drop into both eyes nightly, at bedtime
Vitamin D-3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 125 MCG (5000 UT) , Take 1 Tablet by mouth in the morning Take 1 Tablet by mouth daily in the morning
Lisinopril - Lisinopril 20 mg by mouth once a day

14. DME and Supplies:

rolling walker, 4 wheeled walker, cane

15. Safety Measures:

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

16. Nutrition:

diabetic, renal diet

17. Allergies:

penicillin

18.A. Functional Limitations

Dyspnea With Minimal Exertion, Endurance, Ambulation

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: 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: 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
family/caregiver will be responsible for managing treatment

Homebound status:

After undergoing Left 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 79-year-old female with a past medical history significant for hypertension, hyperlipidemia, and type 2 diabetes mellitus. She underwent a left total knee replacement (L TKR) performed by Dr. Ulric Bigby on September 17, 2025, and was discharged home on September 22, 2025. The reason for the delay in referral for home physical therapy remains unclear. The patient resides with her son, Kim, who provides assistance as needed. The home environment includes 13 steps to enter the residence and an additional 13 steps to access the second-floor bedroom and bathroom, presenting mobility and safety challenges postoperatively. Upon assessment, the patient was alert and oriented to person, place, time, and situation (A&O4). She reports experiencing shortness of breath upon exertion and occasional mild headaches upon waking but denies dizziness, chills, chest pain, or other systemic complaints. Lung sounds were clear bilaterally. She voids without difficulty, reports a normal bowel movement this morning, and demonstrates normoactive bowel sounds. The surgical dressing over the left knee was intact with no evidence of drainage; a photograph and wound measurement were obtained. Pedal pulses were palpable bilaterally. The dressing is to be removed seven days post-procedure by the physician. Physical therapy evaluation revealed decreased endurance, strength, and functional mobility secondary to the recent joint replacement, increasing her risk for falls and dependence in daily activities. The patient exhibited knee pain, reduced left knee strength, unsteady gait, impaired balance, and difficulty with stair negotiation and transfers. These impairments necessitate the use of an assistive device and support from another individual for safe mobility outside the home. Skilled physical therapy services are

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles SN RN on 09/29/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address

Nnaemeka Agajelu
85 Kendrick Way
Glen Burnie, MD 21061
PHONE: 410-553-6360 FAX: 14433543817 NPI: 1104891886

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 : 09/22/2025

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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recommended to improve strength, mobility, transfer safety, balance, and overall functional independence. Education was provided to the patient and caregiver regarding postoperative care and safety. Topics included the causes and management of edema-such as leg elevation above heart level during rest and possible use of compression garments if prescribed by the physician-recognition of infection signs (fever, chills, redness, swelling, discharge, or worsening pain), and management of nausea, vomiting, or persistent pain. Home safety instruction emphasized fall prevention strategies, environmental risk reduction, and proper use of assistive devices. Training included safe transfer techniques with a walker, proper hand and foot placement, and forward weight shift during movement. The patient required minimal assistance to standby assistance (Min A-SBA) for safe transfers. Therapeutic exercises were initiated, including supine ankle pumps, quadriceps sets, gluteal sets (120 each), and heel slides (110). A copy of the home exercise program (HEP) was provided with instructions to perform exercises twice daily. Passive range of motion (PROM) of the left knee was performed in supine position to maintain flexibility and promote joint healing. Ambulation training with a walker was completed on level surfaces under supervision, focusing on proper positioning, step height, step length, and safety awareness. The patient was advised to use the walker consistently for ambulation. The patient was further instructed on the importance of daily ambulation to promote circulation, prevent deconditioning, and reduce postoperative complications. A gradual walking program was recommended, starting with short walks every 1-2 hours within the home and progressing to longer walks lasting 3-5 minutes as tolerated. The patient was also advised to apply ice to the left knee for 20 minutes per session using a protective barrier, with skin checks every 5 minutes during application. Pain is currently well-controlled with prescribed medications. Education was provided on effective pain management, emphasizing timely medication use at the onset of pain and awareness of potential side effects such as dizziness and constipation. The patient was instructed to contact emergency services (911/EMS) or her provider for chest pain, shortness of breath, or unrelieved pain. She was also advised to take pain medication approximately one hour before physical therapy sessions to enhance participation and comfort. Overall, the patient demonstrated good comprehension of education provided and is expected to benefit from continued home physical therapy focused on strengthening, safety, and functional mobility restoration to promote independence and reduce fall risk.
 Date of Order 09/29/2025 Orders Physician Face-to-Face Date: 09/22/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat due to Left 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: Physician Agajelu, Nnaemeka

SN Careplans

SN WK1: 1 (09/26/2025 - 09/27/2025), WK2: 1 (10/05/2025 - 10/11/2025), WK3: 1 (10/12/2025 - 10/18/2025), WK4: 1 (10/19/2025 - 10/24/2025)

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; 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, abn cholesterol > 200 mg/dL, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, constipation, increased urine output, swelling of affected area, limited range of motion, limited strength, Pain Interference with Therapy activities, B1000 - Vision Deficit, balance deficit, headache, Pain Interference with ADLs, Pain Effect on Sleep, bruising/discoloration, #1 - Non-Observable Surgical Wound - Anterior Left Knee -

PROCEDURES: Medication Review- : Medications reviewed with patient caregiver. , cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: To left knee surgical site- dressing to be removed at Physician office., teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, * lifestyle modification to manage blood condition including dietary changes bleeding precautions, related medication(s) purpose, schedule, * low cholesterol dietary guidelines, 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 optimize mental status with cognition therapy home safety optimize mobility with active and passive range of motion therapeutic exercises diet and fluids to optimize peripheral circulation, 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 promote optimized mobility with strength balance dexterity range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing prevent constipation, 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

SN Goals

PATIENT-STATED GOAL: I want to walk without pain

GOALS
patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* 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 cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* 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/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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

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
* low cholesterol dietary guidelines
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to promote optimized mobility with strength
* balance
* dexterity
* range-of-motion therapeutic exercises

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/29/2025

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supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

* promotion of peripheral circulation
* fluid and diet intake to promote healing
* prevent constipation
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to optimize mental status with cognition therapy
* home safety
* optimize mobility with active and passive range of motion therapeutic exercises
* diet and fluids to optimize peripheral circulation
* 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 is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (09/26/2025 - 09/27/2025), WK2: 3 (10/05/2025 - 10/11/2025), WK3: 2 (10/12/2025 - 10/18/2025), WK4: 2 (10/19/2025 - 10/24/2025)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object

PROCEDURES: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., therapeutic modalities: Pt instructed to apply ice to L knee x 20 minutes with necessary barrier and skin assessments q 5 minutes., gait training on uneven surfaces, gait training/stair training, transfers training, assist with infection control: Review signs and symptoms of infection of incision/wound, including fever, chills, redness, swelling, pain, bleeding, or any discharge from the surgical site. Nausea or vomiting that does not get better, or pain that does not get better with medication., assist with fall prevention

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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: I just want to be able to walk

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 04. Supervision or touching

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles SN RN	09/29/2025