

Home Health Certification and Plan of Care				Order ID: 1150/13432	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
01234109		10/23/2025		From: 10/23/2025 To: 12/21/2025	
		4. Medical Record No.		5. Provider No.	
		18441		217058	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Towanda Shields-Davis 2201 Uniontown Rd, Westminster, MD 21158- 240-997-1046			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
10/29/1965			Female		
11. ICD			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
Z47.1			Dulcolax - Bisacodyl 5 mg Oral Tab,Take 2 tablets by mouth once a day by mouth one time with at least 8 ounces of water at 12 noon the day before procedure		
13. ICD			Naprosyn - Naproxen 500 mg Oral Tab,Take 1 tablet by mouth twice a day 2 times a day with meals (Patient not taking: Reported on 7/25/2025)		
Z96.652			Eliquis - Apixaban 5mg by mouth twice a day Taken 2x daily as blood thinner Extra Strength Tylenol - Acetaminophen 500mg by mouth as necessary As needed for pain		
Z86.718			hydroCHLORothiazide (ESIDRIX/HYDRODIURIL) 2 mg Oral Tab,Take 1 tablet by mouth in the morning as needed for pain 1x every 6hrs for pain Vicodin - Acetaminophen: Hydrocodone Bitartrate 325, 1 tablet by mouth every 6 hours for pain Acetaminophen And Hydrocodone Bitartrate - Acetaminophen: Hydrocodone Bitartrate 325mg by mouth twice a day Taking as needed for pain		
14. DME and Supplies:			15. Safety Measures:		
cane, walker			infectious material management, , hand rails, , , ambulates with device, activity supervision		
16. Nutrition:			17. Allergies:		
Z. NO PHYSICIAN-ORDERED DIET			estrogens oxycodone percocet tetracycline		
18.A. Functional Limitations			18.B. Activities Permitted		
Endurance			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: 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		
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.			patient 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: <div>The patient is a 60-year-old female, alert and oriented to person, place, time, and situation, residing in a single-family home with continuous assistance from her husband. She presents as pleasant, cooperative, and optimistic about her recovery following a total knee replacement (TKR). The patient denies pain, reporting a 0/10 on the pain scale, and notes only minimal pressure or tightness around the surgical incision. Her past medical history is notable for a deep vein thrombosis (DVT) in the left leg. Vital signs were obtained and found to be within normal limits, though the patient remarked that her blood pressure was slightly above her typical baseline. The readings were documented and uploaded to her electronic chart. She reports feeling well overall and denies any new or ongoing issues. The patient demonstrates an excellent understanding of her prescribed medications, including their purposes, dosages, and schedules, and reports adherence to the regimen. She also verbalizes knowledge of proper wound management, acknowledging the importance of keeping the surgical site clean and dry until cleared by her surgeon during her postoperative visit. Review of the hospital discharge paperwork revealed no specific wound care instructions for home health nursing. The RN contacted the physician's office to clarify wound care orders, confirm when the current dressing should be removed, and determine if additional wound care is necessary. The patient was informed that she will be updated promptly once the physician provides further direction. A comprehensive physical therapy evaluation was completed following the TKR, focusing on bed mobility, transfers, balance, gait, and overall functional mobility. <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">Assessment</mh> included evaluation of strength, range of motion, endurance, and adherence to postoperative precautions. The patient's home environment and available equipment were reviewed to ensure safety and accessibility. Education was provided regarding safety measures, fall prevention, and a home exercise program to promote recovery. Continued physical therapy was recommended to improve strength, mobility, and functional independence. At this time, the patient remains stable, comfortable, and actively engaged in her recovery process. Education was reinforced on infection prevention, medication adherence, and the importance of promptly reporting any changes in condition to the home health team. The plan of care includes ongoing monitoring of vital signs, verification of wound care orders, adherence to prescribed medications, and continuation of physical therapy to support optimal postoperative outcomes.</div><div> </div><div></div><div>Date of Order</div><div>10/23/2025</div><div>Orders</div><div>Physician Face-to-Face Date: 10/13/2025</div><div>Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left Total Knee Replacement</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div> </div><div><span					
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 10/23/2025					
24. Physician's Name and Address				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.	
Stephen Ilario 655 Watkins Mill Rd Gaithersburg, MD 20879 PHONE: FAX: NPI: 1164425419				F2F date : 10/13/2025	
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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style="white-space: pre; white-space: normal; "> </div><div>1 - SOC - SN Notes: soc</div><div>PT Eval Notes:</div><div> </div><div>Physician</div><div>Ilario, Stephen</div>				

SN Careplans

SN WK1: 1 (10/23/25-10/25/25) ,WK2: 1 (10/26/25-11/01/25)

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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: meal preparation, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M1400 - Dyspnea, limited endurance, limited range of motion, limited strength, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Anterior Left Knee -

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: To surgical joint site- Do not remove the dressing. Dressing to be removed at Post Op visit with the Surgeon. If dressing is saturated or any other issues with the dressing, patient to go to the surgeons office for examination and replacement of the dressing., teach/coordinate/arrange medication packaging and/or administration

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

SN Goals

PATIENT-STATED GOAL: To get stronger

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

- * 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 self-administers medications as prescribed

- * recalls related medication(s) purpose, schedule

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 Goals
Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	10/23/2025

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PT WK1: 2 (10/23/25-10/25/25) ,WK2: 2 (10/26/25-11/01/25) ,WK3: 2 (11/02/25-11/08/25) PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170J1 - Walk 50 ft with 2 Turns, 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, GG0130B1 - Oral Hygiene, GG0170I1 - Walk 10 Feet, 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: B LE strengthening, Standing balance Training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training 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, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 06. Independent, 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 - 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		PATIENT-STATED GOAL: To have a successful post op procedure GOALS Chair to Bed to Chair - 06. Independent Toilet Transfer - 06. Independent Oral Hygiene - 06. Independent Lower Body Dressing - 06. Independent Shower/Bathe Self - 06. Independent Toileting Hygiene - 06. Independent Don/Doff Footwear - 06. Independent Eating - 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 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		

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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