Home Health Certification and Plan of Care

Order ID: 1150/13624

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
33129865	11/05/2025	From: 11/05/2025 To: 01/03/2026	18439	217058

6. Patient's Name and Address

Sadie Brunson
3923 Mortimer Ave,
BALTIMORE, MD 21215-
410-800-8943

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 05/02/1939 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	11/05/25

13. ICD	Other Pertinent Diagnoses	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	11/05/25
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	11/05/25
N18.32	Chronic kidney disease stage 3b	11/05/25
I70.0	Atherosclerosis of aorta	11/05/25
M54.50	Low back pain unspecified	11/05/25
G89.29	Other chronic pain	11/05/25
M85.80	Oth disrd of bone density and structure unspecified site	11/05/25
G25.81	Restless legs syndrome	11/05/25
J45.909	Unspecified asthma uncomplicated	11/05/25
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	11/05/25
G47.00	Insomnia unspecified	11/05/25
E78.5	Hyperlipidemia unspecified	11/05/25
E55.9	Vitamin D deficiency unspecified	11/05/25
J30.9	Allergic rhinitis unspecified	11/05/25
Z79.84	Long term (current) use of oral hypoglycemic drugs	11/05/25
Z96.653	Presence of artificial knee joint bilateral	11/05/25
Z90.49	Acquired absence of other specified parts of digestive tract	11/05/25
Z86.0100	Personal history of colonic polyps	11/05/25

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

Neurontin - Gabapentin 100 mg, Take 2 capsules by mouth twice a day new dosage 6/2025
Glucotrol - Glipizide 5 mg, Take 1 tablet by mouth in the morning Take 1 tablet by mouth every morning 30 minutes before a meal for diabetes (new 3/2025)
Lopressor - Metoprolol Tartrate 50 mg, Take 1 tablet by mouth twice a day
Desyrel - Trazodone Hydrochloride 50 mg, Take 1 tablet by mouth at bedtime Take 1 tablet by mouth at bedtime as needed for sleep
Glucophage - Metformin Hydrochloride 500 mg, Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day with meals for diabetes (lower dosage 8/1/23)
Norvasc - Amlodipine Besylate 10 mg, Take 1 tablet by mouth once a day
Lipitor - Atorvastatin Calcium 80 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for cholesterol and heart protection
Estrace - Estradiol 0.01 % (0.1 mg/gram), Insert 1 gram vaginally vaginal as necessary Insert 1 gram vaginally daily at bedtime For 1 week, then insert 1 gram vaginally 2 times per week
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 4 hours Post surgical pain
Colace - Docusate Sodium 100mg by mouth twice a day 2 tabs for stool softner
Aspirin - Aspirin 81mg by mouth twice a day
Extra Strength Tylenol - Acetaminophen 500mg by mouth every 6 hours 3 times a day for pain with inflammation

14. DME and Supplies:

diabetic supplies, walker

15. Safety Measures:

infectious material management, diabetic precautions, , walker precautions, supervision at all times, , bathroom safety, activity supervision, ambulates with assistance, ambulates with device

16. Nutrition:

low cholesterol, low sodium

17. Allergies:

lisinopril

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, 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

Homebound status: After undergoing Left Knee Joint 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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 11/05/2025

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 : 10/29/2025

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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Clinical Condition Requiring Homecare:

The patient is an 86-year-old female, alert and oriented 4, status post left total knee arthroplasty performed by Dr. Huang. Her past medical history includes a previous right total knee arthroplasty. The patient currently requires the use of an assistive device for ambulation to promote safety and prevent accidental falls, making it a taxing effort for her to leave home. She reports significant left knee pain rated at 10/10, with the last dose of Tylenol taken prior to hospital discharge the previous day. She also reports being unable to go upstairs last night due to pain but denies any recent falls, dizziness, or lightheadedness. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, swelling is noted to the left knee, but no abnormal drainage or bleeding is observed at the incision site. The dressing remains clean, dry, and intact. Lungs are clear to auscultation bilaterally, with no adventitious sounds. The patient demonstrates a deep, effective cough and was instructed and able to correctly demonstrate the use of the incentive spirometer to promote pulmonary hygiene. She denies nausea, vomiting, abdominal discomfort, or urinary pain, and reports a good appetite. Her last bowel movement occurred on Monday prior to surgery; therefore, education was provided regarding bowel regimen management, including the use of stool softeners, increased hydration, and mobility as tolerated to promote regularity. Patient education focused on postoperative care and pain management. The patient was instructed on the role of inflammation in postoperative pain and swelling, as well as the importance of adhering to her prescribed pain regimen, which includes alternating anti-inflammatory medications with Tylenol every six hours, taking medication with food to prevent gastrointestinal irritation, and utilizing ice therapy, elevation, compression, and NSAIDs as directed to minimize edema and discomfort. The nurse reviewed incision care instructions, emphasizing that the site should not be soaked or exposed to water until cleared by the surgeon. The patient was advised to immediately contact Dr. Huang for any increase in bruising, drainage, pain, or swelling despite ongoing conservative management. Medications were reviewed thoroughly with the patient and her caregivers (brother and sister-in-law) for proper understanding of each medication's indication, dosage, and timing; a written medication schedule was provided for visual reference. Physical therapy evaluation revealed decreased left lower extremity strength at 2-/5 on manual muscle testing, with marked pain limiting mobility and weight bearing. The patient currently requires moderate-to-maximum assistance to stand from the couch and is unable to tolerate ambulation. The therapist advised her to use a higher, sturdy chair with armrests instead of the couch for improved leverage and safety during transfers. A home exercise program (HEP) was introduced, including quadriceps sets, ankle pumps, and gentle knee flexion exercises (10 repetitions, twice daily), to promote circulation, maintain range of motion, and prevent stiffness. The plan of care includes ongoing skilled nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> for incision and wound <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, pain and medication management, reinforcement of postoperative education, and coordination of care with physical therapy for progressive strengthening, mobility, and functional independence. The patient has a scheduled follow-up with Dr. Huang and remains motivated and cooperative with her recovery plan.
 Date of Order 11/05/2025 Orders Physician Face-to-Face Date: 10/29/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left Knee Joint 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 WK1: 1 (11/05/25-11/08/25) ,WK2: 1 (11/09/25-11/15/25)

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, blood sugar < 60 > 300

CAREGIVER: 1. Non-agency caregiver(s) currently 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 ; 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.

s/p left knee joint replacement dressing remove 7-day post-surgery dressing removed measure incision and photograph
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M2102d - Caregiver

SN Goals

PATIENT-STATED GOAL: decrease pain and left knee to heal like the right knee did

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
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* 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
* 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 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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/05/2025

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Performs Treatment, meal preparation, M1400 - Dyspnea, swelling in the arms/legs, abn cholesterol > 200 mg/dL, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, constipation, M1610 - Urinary Incontinence, increased urine output, limited endurance, swelling of affected area, limited strength, muscle weakness, Pain Effect on Sleep, balance deficit, pain radiating to arms/legs, Pain Interference with ADLs, Pain Interference with Therapy activities, obesity, swell/redness surround. skin, red/tender pressure points, #1 - Non-Observable Surgical Wound - Anterior Left Knee -

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 left 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., glucose testing via monitor, monitor intake & output

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, * 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 manage sleep disorder including changes to daytime habits and bedtime routine maintaining a journal to track 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, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * lifestyle modifications low-residue dietary guidelines alternative medicine options for ulcerative colitis, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

* 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
* low-residue dietary guidelines
* alternative medicine options for ulcerative colitis
* 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
* low cholesterol dietary guidelines
* 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 2 (11/05/25-11/08/25) ,WK2: 3 (11/09/25-11/15/25) ,WK3: 1 (11/16/25-11/22/25)

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: Medication Review : - medications reviewed with patient/caregiver, cough/deep breathing exercises, incentive spirometer, gait training on uneven surfaces, gait training/stair training, transfers training, therapeutic exercises

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 - 03. Partial/moderate assistance, Upper Body Dressing - 03. Partial/moderate assistance, Lower Body Dressing - 03. Partial/moderate assistance, Shower/Bathe Self - 04. Supervision or touching assistance, Toileting Hygiene - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 04. Supervision or touching assistance, Car Transfer - 04. Supervision or touching assistance, Walk 10 Feet - 03. Partial/moderate assistance, Walk 50 ft with 2 Turns - 03. Partial/moderate assistance, Walk 150 Feet - 03. Partial/moderate assistance, 1 - Step (curb) - 03. Partial/moderate assistance, 4 Steps - 03. Partial/moderate assistance, 12 Steps - 03. Partial/moderate assistance, Picking Up Object - 03. Partial/moderate assistance, Medication Review

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

GOALS
Shower/Bathe Self - 04. Supervision or touching assistance

Eating - 06. Independent

Toilet Transfer - 04. Supervision or touching assistance

Car Transfer - 04. Supervision or touching assistance

1 - Step (curb) - 03. Partial/moderate assistance

4 Steps - 03. Partial/moderate assistance

12 Steps - 03. Partial/moderate assistance

Picking Up Object - 03. Partial/moderate assistance

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

Oral Hygiene - 03. Partial/moderate assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

11/05/2025

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Oral Hygiene - 03. Partial/moderate assistance

Sit to Stand - 04. Supervision or touching assistance

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

Medication Review

Upper Body Dressing - 03. Partial/moderate assistance

Lower Body Dressing - 03. Partial/moderate assistance

Toileting Hygiene - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Walk 10 Feet - 03. Partial/moderate assistance

Walk 50 ft with 2 Turns - 03. Partial/moderate assistance

Walk 150 Feet - 03. Partial/moderate assistance

Signature of Physician:	Date
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