Home Health Certification and Plan of Care

Order ID: 1150/13779

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
26130787	11/06/2025	From: 11/06/2025 To: 01/04/2026	18535	217058

6. Patient's Name and Address
Kimberly Cooper
5647 Harbor Valley Dr,
BROOKLYN PARK, MD 21225-
410-227-0106

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 10/20/1969 | 9.Sex Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	11/06/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	11/06/25
M17.12	Unilateral primary osteoarthritis left knee	11/06/25
I10.	Essential (primary) hypertension	11/06/25
J45.909	Unspecified asthma uncomplicated	11/06/25
E78.5	Hyperlipidemia unspecified	11/06/25
I87.2	Venous insufficiency (chronic) (peripheral)	11/06/25
D35.02	Benign neoplasm of left adrenal gland	11/06/25
K21.9	Gastro-esophageal reflux disease without esophagitis	11/06/25
F41.9	Anxiety disorder unspecified	11/06/25
F32.A	Depression unspecified	11/06/25
E66.9	Obesity unspecified	11/06/25
Z68.35	Body mass index [BMI] 35.0-35.9 adult	11/06/25
Z90.710	Acquired absence of both cervix and uterus	11/06/25
Z86.0100	Personal history of colonic polyps	11/06/25
Z87.891	Personal history of nicotine dependence	11/06/25

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

WIXELA INHUB 250-50 mcg/dose Inhale 1 puff by mouth twice a day (Controller inhaler)
Mobic - Meloxicam 15 mg Oral Tab,Take 1 tablet by mouth once a day
Inderal - Propranolol Hydrochloride 10 mg Oral Tab,Take 1 tablet by mouth three times a day
Lexapro - Escitalopram Oxalate 20 mg Oral Tab,Take 1 tablet by mouth once a day
Norvasc - Amlodipine Besylate 10 mg Oral Tab,Take 1 tablet by mouth once a day
Zovirax - Acyclovir Sodium 400 MG Oral Tablet,take 1 tablet by mouth three times a day a day for 5 days
Albuterol (PROAIR/PROVENTIL/VENTOLIN) 90 mcg/actuation Inhale 2 Puffs by mouth twice a day Inhale 2 Puffs by mouth 2 times a day as needed for quick relief of asthma symptoms or shortness of breath or cough or wheezing
Nexium - Esomeprazole Magnesium Take 20 mg Oral CPDR SR Cap, by mouth once a day 30 minutes before a meal
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 mg (65 mg iron) Oral Tab,Take 1 tablet by mouth three times a day after meals
Lactobacillus Acidophilus (BACID) take 1 oral cap by mouth once a day take one cap po BID
Temovate - Clobetasol Propionate 0.05 % apply this affected area topical as necessary Not for face, armpit, groin areas unless otherwise instructed. Apply this topical steroid medication to affected areas twice daily no more than 5 days a week. Repeat weekly. Decrease frequency of use as skin improves.
Cozaar - Losartan Potassium 100 mg, take 1 tablet by mouth once a day
Oxaydo - Oxycodone Hydrochloride 5mg by mouth every 4 hours Severe pain
Colace - Docusate Sodium 100mg by mouth twice a day Constipation

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 11/06/2025

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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Extra Strength Tylenol - Acetaminophen 1000 by mouth every 8 hours Moderate pain
Aspirin 81Mg - Aspirin 81 by mouth every 8 hours

14. DME and Supplies:

walker, hand held shower, grab bars, cane

15. Safety Measures:

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

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

bactrim ds doxycycline zithromax effexor latex paxil

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: 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 Right 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 56-year-old female who underwent a right total knee replacement (TKR) on November 5, 2025, at an ambulatory surgical center (ASC). She returned home the same day with family assistance and currently resides with her daughter and grandchildren. The patient is alert and oriented 4, ambulates with a walker and cane, and demonstrates understanding of safety precautions. Her past medical history includes hypertension, right knee arthritis, and asthma. She denies chest pain, palpitations, and dizziness but reports shortness of breath upon exertion. Lung sounds are clear but diminished at the bases. She voids without complications, and her last bowel movement was yesterday with normoactive bowel sounds. Pedal pulses are present bilaterally, and surgical incision photo documentation was obtained. Pain is well controlled with current medication. The patient was educated on medication actions, side effects, and proper timing of analgesics-particularly taking pain medication approximately one hour before physical therapy sessions-to optimize comfort and mobility. Education was also provided on recognizing signs and symptoms of infection (fever, chills, redness, swelling, drainage, or unrelieved pain), deep vein thrombosis (DVT), and proper use of the incentive spirometer to promote pulmonary hygiene. The patient verbalized understanding and agreed with the teaching provided. During the initial physical therapy evaluation, the patient presented with knee pain, decreased strength in the right knee, reduced functional mobility, difficulty negotiating stairs, unsteady gait, impaired transfers, decreased balance, and limited safety awareness-all contributing to an elevated fall risk. Skilled home physical therapy was recommended to address these deficits and promote safe functional recovery. The physical therapist obtained consents and developed a plan of care (POC) to improve strength, ambulation, transfers, balance, and safety awareness to restore independence. The patient and primary caregiver were instructed on the causes of edema and positioning strategies to reduce swelling, including leg elevation above heart level during rest periods and use of compression garments as recommended by the physician. Education on home safety and fall prevention was provided per pages 32-33 of the patient handbook, emphasizing removal of trip hazards, proper lighting, and cautious use of assistive devices. The patient was instructed and practiced safe transfer techniques using the walker, with cues for appropriate hand and foot placement, forward weight shifting, and reaching back to the chair before sitting. She required minimal assistance to standby assistance for safe transfers and bed mobility. Therapeutic exercises included supine ankle pumps, quadriceps sets, gluteal sets (120), and heel slides (110). Passive range of motion (PROM) exercises of the right knee were performed in the supine position. A copy of the home exercise program (HEP) was left with written instructions to perform twice daily. The patient was instructed on safe ambulation using a walker, requiring standby assistance with cues for proper posture, walker positioning, and step length. She was advised to ambulate with the walker at all times for safety. A progressive walking program was introduced-short walks every 1-2 hours, 1-2 times daily, starting with 3-5 minutes and increasing gradually as tolerated. The importance of regular ambulation for circulation and prevention of complications from inactivity was emphasized. Ice therapy was recommended for the right knee for 20 minutes per session with a protective barrier, checking skin integrity every 5 minutes. The patient was also instructed to call 911 or her healthcare provider if experiencing chest pain, shortness of breath, or unrelieved pain. She demonstrated good understanding of all instructions provided. The physical therapy plan of care was discussed and agreed upon, with scheduled home PT sessions beginning November 6, 2025, at a frequency of 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> the first week (Thursday/Friday), 3 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> the following week (Monday/Tuesday/Thursday), and 1 visit the subsequent week (Monday). The patient is scheduled to transition to outpatient physical therapy on November 20, 2025, and will follow up with Dr. Huang on November 19, 2025. Continued skilled physical therapy and nursing care are indicated to promote safe recovery, prevent complications, and facilitate the patient's return to independent function.
 Date of Order 11/06/2025 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 Right 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: eval
 Physician Huang , James

SN Careplans

SN WK1: 1 (11/06/25-11/08/25) ,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

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

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 manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

11/06/2025

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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: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M2102c - Med Admin, M1400 - Dyspnea, wheezing, abnormal blood pressure, constipation, swelling of affected area, limited range of motion, muscle weakness, muscle spasms, limited endurance, limited strength, Pain Interference with Therapy activities, balance deficit, Pain Interference with ADLs, Pain Effect on Sleep, swell/redness surround. skin, bruising/discoloration, #1 - Non-Observable Surgical Wound - Anterior Right Knee -

PROCEDURES: 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/coordinate/arrange medication packaging and/or administration

TEACH PATIENT/CAREGIVER: * 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, * 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, * 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, 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

* prevent constipation
* home safety
* 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
* 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 self-administers medications as prescribed
* 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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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: 2 (11/06/25-11/08/25) ,WK2: 3 (11/09/25-11/15/25) ,WK3: 1 (11/16/25-11/22/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: home exercise program, home exercise program, home exercise program: Supine-seated standing HEP Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ hip flex, Standing-Mini squat, heel/toe raise, hip flex, leg curls.,

PT Goals

PATIENT-STATED GOAL: I want to be able to walk normal, without pain, and to be able to get up and down my steps.

GOALS
Shower/Bathe Self - 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

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

patient/caregiver recalls

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	11/06/2025

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therapeutic modalities: Apply ice to R 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, assist with fall prevention

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 - 05. Setup or clean-up assistance, 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 - 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

* 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

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Car Transfer - 06. Independent

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

Oral Hygiene - 06. Independent

Eating - 06. Independent

Sit to Stand - 06. Independent

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

Signature of Physician:	Date
	PAGE 4 of 4
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