Home Health Certification and Plan of Care

Order ID: 1150/13827

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
681295030	11/07/2025	From: 11/07/2025 To: 01/05/2026	18678	217058

6. Patient's Name and Address
Kathy Kingsley
224 Cedarmere Circle,
OWINGS MILLS, MD 21117-
443-797-3803

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 09/17/1963 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	11/07/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	11/07/25
M17.12	Unilateral primary osteoarthritis left knee	11/07/25
I10.	Essential (primary) hypertension	11/07/25
G56.21	Lesion of ulnar nerve right upper limb	11/07/25
G56.01	Carpal tunnel syndrome right upper limb	11/07/25
E55.9	Vitamin D deficiency unspecified	11/07/25
E78.5	Hyperlipidemia unspecified	11/07/25
E66.9	Obesity unspecified	11/07/25
Z68.32	Body mass index [BMI] 32.0-32.9 adult	11/07/25
Z86.0100	Personal history of colonic polyps	11/07/25
Z90.710	Acquired absence of both cervix and uterus	11/07/25
Z87.891	Personal history of nicotine dependence	11/07/25

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

Aspirin - Aspirin 81mg by mouth twice a day Blood thinner
Docusate Sodium - Docusate Sodium 100mg by mouth once a day Stool softner
Lipitor - Atorvastatin Calcium eq 20 mg base 20 mg tablet by mouth once a day take 1 tablet by mouth daily for cholesterol & heart protection
Acetaminophen And Codeine Phosphate - Acetaminophen: Codeine Phosphate 300 mg;15 mg 30mg by mouth every 4 hours Taking for pain
Hydrochlorothiazide - Hydrochlorothiazide 25 mg 25 mg tablet by mouth once a day take 1 tablet by mouth daily

14. DME and Supplies:
grab bars, walker, cane

15. Safety Measures:
bathroom safety, , infectious material management, , knee precautions, activity supervision, smoke detectors , restricted ROM, , ambulates with device

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
sulfa antibiotics

18.A. Functional Limitations
Ambulation

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: 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:
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.

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 62-year-old female, alert and oriented 4, evaluated at home one day following a right total knee replacement. Her past medical history is significant for hysterectomy, hyperlipidemia (HLD), hypertension (HTN), obesity, and right carpal tunnel syndrome (CTS). She reports a pain level of 2/10 after taking her prescribed pain medication approximately one hour prior to the visit and states she is managing well with the assistance of her daughter. The patient demonstrates understanding of post-operative precautions, including maintaining a dry incision site and adhering to fall prevention measures. On examination, the Aquacel dressing to the right knee was clean, dry, and intact, with no drainage or signs of infection observed. Vital signs were within normal limits. The patient ambulates with a rolling walker (RW) and displays a steady gait. Range of motion (ROM) of the right knee measured 5-95 degrees for flexion and extension with overpressure, with noted limitations in ROM, strength, endurance, standing balance, and overall functional mobility. Timed Up and Go (TUG) test was completed in 11 seconds, indicating a reduced fall risk. The patient currently performs sit-to-stand transfers independently using the RW, requires supervision for indoor ambulation and stair negotiation, and benefits from assistance as needed for safety. Pain remains well controlled, and no post-operative complications are noted at this time. Education was reinforced regarding wound care, fall prevention, and the medication regimen. The patient was instructed to keep the incision dry and report any increase in pain, redness, drainage, or fever. The home exercise program (HEP), including seated and standing therapeutic exercises, was reviewed, and the patient was advised to ambulate hourly as tolerated to improve mobility and circulation. The registered nurse (RN) will return in seven days for dressing removal, after which the wound will remain open to air for continued healing. The patient verbalized understanding of all instructions. Skilled physical therapy services are recommended to address current deficits, enhance strength, balance, and endurance, and promote safe and independent return to her prior level of function (PLOF).
 Date of Order 11/07/2025 Orders Physician Face-to-Face Date: 10/30/2025 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:
 Physician Huang , James

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 11/07/2025

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 : 10/30/2025

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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SN WK1: 1 (11/07/25-11/08/25) ,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: 10. None of the above

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: M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M2020 - Oral Med Management, M1400 - Dyspnea, muscle weakness, limited range of motion, limited strength, limited endurance, Pain Interference with ADLs, #1 - Non-Observable Surgical Wound - Anterior Right Knee - Aquacel Dressing to remain intact for 7 days post-op unless visibly soiled, Dressing to be removed 7 days post op by Therapist

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 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: * 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, * 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

PATIENT-STATED GOAL: "To fully recover and get back to work."

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
* prevent constipation
* home safety
* 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
* 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 is adequately supervised

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	11/07/2025

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PT WK1: 1 (11/07/25-11/08/25) ,WK2: 3 (11/09/25-11/15/25) ,WK3: 2 (11/16/25-11/22/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: Therapeutic exercise , Dynamic standing balance , Medication Review- Medications reviewed with patient/caregiver., 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 - 05. Setup or clean-up assistance, 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, Medication Review- Patient/caregiver, related purpose and schedule of medications.

PATIENT-STATED GOAL: To walk independently

GOALS
Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

1 - Step (curb) - 05. Setup or clean-up assistance

Eating - 05. Setup or clean-up assistance

Car Transfer - 06. Independent

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

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

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 - 06. Independent

Lower Body Dressing - 06. Independent

Shower/Bathe Self - 03. Partial/moderate assistance

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Sit to Stand - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Medication Review- Patient/caregiver recalls related purpose and schedule of medications.

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
11/07/2025