Home Health Certification and Plan of Care

Order ID: 1150/14595

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
081094291	12/03/2025	From: 12/03/2025 To: 01/31/2026	19394	217058

6. Patient's Name and Address
Marilyn Apfel
1228 Chesapeake Dr,
CHURCHTON, MD 20733-
301-379-2154

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 02/25/1945 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	12/03/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	12/03/25
I10.	Essential (primary) hypertension	12/03/25
G47.33	Obstructive sleep apnea (adult) (pediatric)	12/03/25
M85.80	Oth disrd of bone density and structure unspecified site	12/03/25
H43.812	Vitreous degeneration left eye	12/03/25
Z86.0100	Personal history of colonic polyps	12/03/25
Z87.891	Personal history of nicotine dependence	12/03/25
Z86.16	Personal history of COVID-19	12/03/25

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

Lipitor - Atorvastatin Calcium 20 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for cholesterol to prevent heart attack and stroke
Hydrochlorothiazide - Hydrochlorothiazide 50 mg/5ml 25 mg , Take 1 tablet by mouth once a day
Verapamil - Verapamil Hydrochloride 180 mg, Take 1 tablet by mouth once a day
Vasotec - Enalapril Maleate 5 mg,Take 1 tablet by mouth once a day
Fluticasone - Fluticasone Furoate 50 mcg/actuation , Use 1 Spray nasal once a day Use 1 Spray in each nostril daily
Benzonatate - Benzonatate 100 mg , Take 1 capsule by mouth every 8 hours Take 1 capsule by mouth every 8 hours as needed for cough
Doxycycline Hyclate - Doxycycline Hyclate 100 mg, Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day
Ascorbic Acid - Ascorbic Acid: Biotin: Cyanocobalamin: Dexpanthenol: Ergocalciferol: Folic Acid: Niacinamide: Pyridoxine Hydrochloride: Riboflav 500 mg , Take 2 tablets by mouth every other day
Co Q 10 - Coenzyme Q10 100 mg , Take 1 capsule by mouth once a day Take 1 capsule by mouth daily Take 300mg QOD
Calcium-Vit D3-Vit K (CALCIUM FOR WOMEN) 500-100-40 mg-unit-mcg Oral Chew Tab 500-100-40 mg-unit-mcg Oral Chew Tab, 1 Tablet by mouth twice a day at bedtime
Multivitamin - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 Tablet by mouth once a day 1 po qd
Astelin - Azelastine Hydrochloride 137 mcg (0.1 %) ,Use 1 Spray Nasal twice a day Use 1 Spray in each nostril 2 times a day
Oxycodone 5/Apap 500 - Acetaminophen: Oxycodone Hydrochloride 1 Tablet by mouth every 4 hours As needed for pain
Colace - Docusate Sodium 1-2 cap by mouth once a day As needed for constipation

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

15. Safety Measures:
, , infectious material management, walker precautions, , no bending, knee precautions, , ambulates with device

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations

18.B. Activities Permitted

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 12/03/2025

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 : 11/17/2025

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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Ambulation	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: 8. Patient unable to respond, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: good

22. A Rehabilitation Potential:
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., 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 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 an 80-year-old female with a past medical history significant for osteoarthritis of the left knee, status post left total knee replacement on 12/1/25, who returned home the following day with continuous assistance from her spouse. Upon skilled nursing and physical therapy evaluation, the patient was alert and oriented to person, place, and time, resting comfortably on the couch with her husband present. She denied chest pain or discomfort and reported a pain level of 0 at rest and 1 with ambulation, stating she is taking her prescribed pain medication as directed. Pain is currently well controlled. A cold therapy unit with an ice pack was in place to the left knee and being used as prescribed. The non-removable surgical dressing was clean, dry, and intact, with removal scheduled for 08/08/25. The patient reported constipation with no bowel movement for three days and is currently on a bowel regimen; she was educated on the use of docusate (Colace) and instructed to notify her physician if no bowel movement occurs. No swelling was noted in the bilateral lower extremities, and TED stockings were in place as prescribed. Medications were reviewed with no discrepancies, missing medications, or refill needs identified. Admission paperwork was completed, and the patient verbalized understanding of and agreement with the plan of care. Physical therapy evaluation identified deficits including left knee pain, decreased strength, impaired functional mobility, difficulty with transfers and stair negotiation, unsteady gait, decreased balance, reduced safety awareness, and increased fall risk. The patient requires assistance from another person and an assistive device to safely leave the home and currently needs minimal assistance to standby assistance for transfers, bed mobility, and safe ambulation with a walker on level surfaces. Education was provided to the patient and caregiver regarding edema management through elevation of the lower extremities above heart level and use of compression garments if prescribed, with verbalized understanding. Signs and symptoms of infection, including fever, chills, redness, swelling, drainage, unrelieved pain, nausea, or vomiting, were reviewed. Extensive fall prevention and home safety education was provided based on the patient handbook, including safe transfer techniques with proper hand and foot placement, forward weight shift, and reaching back prior to sitting. The patient was instructed and assisted in safe sofa and bed mobility techniques to promote independence. A home exercise program was initiated, including supine ankle pumps, quadriceps sets, and gluteal sets (1 set of 20 repetitions) and heel slides (1 set of 10 repetitions), with instructions to perform twice daily and a written copy left in the home. The patient was instructed in safe ambulation with a walker, emphasizing proper positioning, increased step height and length, and continuous use of the walker at all times. Education was provided on the benefits of daily ambulation to promote circulation and prevent complications of immobility, with a walking program initiated consisting of short walks every 1-2 hours in the home and progression to longer walks starting at 3-5 minutes as tolerated. Ice application to the left knee was reinforced for 20 minutes with a protective barrier and skin checks every 5 minutes. The patient was further educated on effective pain management, potential side effects of pain medication including dizziness and constipation, and to seek emergency care for chest pain, shortness of breath, or unrelieved pain; she was also instructed to take pain medication approximately one hour prior to physical therapy sessions, with verbalized understanding. The physical therapy plan of care was discussed and developed collaboratively with the patient and caregiver, with full agreement. The patient is scheduled for home physical therapy beginning 12/4/25 with a structured visit frequency and plans to transition to outpatient physical therapy following follow-up with Dr. Huang on 12/15/25. Ongoing skilled nursing and therapy services will continue for postoperative monitoring, safety, mobility progression, and fall prevention.
 Date of Order 12/03/2025 Orders Physician Face-to-Face Date: 11/17/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & 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: eval Physician Huang , James

SN Careplans

SN WK1: 1 (12/03/25-12/06/25) ,WK2: 1 (12/07/25-12/13/25)

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: 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; 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

SN Goals

PATIENT-STATED GOAL: to go to outpatient and be able to walk without pain again

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/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
Electronically Signed by Messick, Charles RN	12/03/2025

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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: M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, abnormal bowel sounds, swelling of affected area, limited range of motion, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, loss of appetite, bruising/discoloration, #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: 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 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

PT Careplans

PT WK1: 1 (12/03/25-12/06/25) ,WK2: 3 (12/07/25-12/13/25) ,WK3: 2 (12/14/25-12/20/25)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, 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: home exercise program: 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., 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, 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, 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 - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 06. Independent, Car Transfer - 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, 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: To be able to walk independently with my cane

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

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

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Don/Doff Footwear - 06. Independent

Oral Hygiene - 06. Independent

Eating - 06. Independent

Sit to Stand - 04. Supervision or touching assistance

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

Car Transfer - 04. Supervision or touching assistance

Walk 10 Feet - 04. Supervision or touching assistance

Signature of Physician:	Date
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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

Signature of Physician:

Date

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

Date
12/03/2025