Home Health Certification and Plan of Care

Order ID: 1150/14749

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
01245835	12/09/2025	From: 12/09/2025 To: 02/06/2026	18878	217058

6. Patient's Name and Address

Mario Romero
29 Upman Ct,
CATONSVILLE, MD 21228-
410-409-2839

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 08/28/1952 | 9.Sex Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	12/09/25

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	12/09/25
D3A.8	Other benign neuroendocrine tumors	12/09/25
E11.65	Type 2 diabetes mellitus with hyperglycemia	12/09/25
I10.	Essential (primary) hypertension	12/09/25
I70.0	Atherosclerosis of aorta	12/09/25
J45.909	Unspecified asthma uncomplicated	12/09/25
M54.12	Radiculopathy cervical region	12/09/25
N43.3	Hydrocele unspecified	12/09/25
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	12/09/25
N28.1	Cyst of kidney acquired	12/09/25
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	12/09/25
E78.5	Hyperlipidemia unspecified	12/09/25
Z79.51	Long term (current) use of inhaled steroids	12/09/25
Z79.82	Long term (current) use of aspirin	12/09/25
Z79.4	Long term (current) use of insulin	12/09/25
Z86.0100	Personal history of colonic polyps	12/09/25
Z90.49	Acquired absence of other specified parts of digestive tract	12/09/25

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

Aspirin - Aspirin 81 mg , Take 1 tablet by mouth twice a day POST OP LEFT KNEE REPLACEMENT
Colace - Docusate Sodium 100MG; 1 TAB inhalant twice a day STOOL SOFTNER
Cosopt - Dorzolamide Hydrochloride: Timolol Maleate 22.3-6.8 mg/mL, Instill 1 drop both eyes twice a day GLAUCOMA
Dulcolax - Bisacodyl 5 mg, Take 10 mg by mouth every other day Take 10 mg by mouth every other day as needed
Ergocalciferol - Ergocalciferol 50,000 International Units 1,250MG; 1 TAB by mouth once a week SUPPLEMEENT
Lasix - Furosemide 20 mg 20 mg, Take 1 tablet by mouth in the morning FLUID PILL
Humalog - Insulin Lispro Recombinant 100 units/ml 100 unit/mL, Inject 1 to 10 units subcutaneous three times a day Inject 1 to 10 units subcutaneously 3 times a day before meals. Sliding Scale: inject within 15 minutes of a meal
Blood sugar less than 150 use 0 units,151 200 use 2 units, 201 250 use 4 units, 251 300 use 6 units, 301 350 use 8 units, 351 400 use 10 units, if greater than 400 use 10 units and call MD
Roxicodone - Oxycodone Hydrochloride 5 mg, Take 1 tablet by mouth every 6 hours Take 1 tablet by mouth every 6 hours as needed for severe pain
Narcan - Naloxone Hydrochloride 4 mg/actuation, Spray contents in 1 Nasal as necessary Spray contents in 1 nostril for adult or child not breathing or responding. Call 911. If pt still not breathing/responding, use new spray in 2 to 3 mins in other nostril. For suspected opioid overdose use only (Patient not taking: Reported on 10/22/2025)
Humulin N - Insulin Susp Isophane Recombinant Human 40 UNITS subcutaneous twice a day DIABETES
Cozaar - Losartan Potassium 50 mg 50 mg, Take 1 tablet by mouth once a day BLOOD PRESSURE
Mobic - Meloxicam 15 mg 15 mg, Take 1 tablet by mouth once a day PAIN
Vigamox - Moxifloxacin Hydrochloride 0.5 %,Instill 1 Drop left eye four times a day LEFT EYE
Zocor - Simvastatin 80 mg,Take 1 tablet by mouth once a day Take 1 tablet by mouth every evening for cholesterol
Fluticasone-Salmeterol (WIXELA INHUB) 500-50 mcg/dose Inhl Disk w/devi Inhale 1 puff by mouth twice a day
Isopto Atropine - Atropine Sulfate 1 %, Instill 1 drop left eye three times a day LEFT EYE BLINDNESS
Tylenol - Acetaminophen 500 mg, Take 2 tablets by mouth every 6 hours Take 2 tablets by mouth every 6 hours as needed for mild pain
Zyrtec - Cetirizine Hydrochloride 10 mg, Take 1 tablet by mouth once a day

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 12/09/2025

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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ALLERGIES
Flomax - Tamsulosin Hydrochloride 0.4 mg 0.4 mg, Take 1 capsule by mouth at bedtime Take 1 capsule by
mouth daily at
bedtime
BPH
Viagra - Sildenafil Citrate eq 100 mg base 100 mg, Take 1 tablet by mouth as necessary Take 1 tablet by
mouth as needed 1
hour before sexual
activity. Do not
exceed 1 dose (1
tablet) in 24 hours
Proventil - Albuterol 90 mcg/actuation, Inhale 1 puff inhalant every 4 hours Inhale 1 puff by
mouth every 4 hours
as needed (Rescue
inhaler) for SOC
Omeprazole - Omeprazole 20 mg 1 by mouth once a day
Cephalexin - Cephalexin eq 500 mg base 500mg; 1 cap by mouth every 8 hours for knee infection r/t bandage for 14 days
Doxycycline Hyclate - Doxycycline Hyclate eq 20 mg base 20mg; 1 tab by mouth twice a day for knee infection r/t bandage for 14 days
Ibuprofen - Ibuprofen 200 mg 200mg; 4 tabs by mouth every 8 hours as needed for pain

14. DME and Supplies:

walker, cane, ELEVATED TOILET SEAT

15. Safety Measures:

infectious material management, standard precautions, knee precautions, ambulates with device, walker precautions, medication safety, emergency phone # clearly displayed, ambulates with assistance, transfer with assist, supervision at all times, sharps precautions, fall precautions, diabetic precautions, bleeding precautions, anticoagulant precautions, activity supervision

16. Nutrition:

diabetic, cardiac diet

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance, LEFT EYE BLINDNESS

18.B. Activities Permitted

Cane, Walker, Exercises Prescribed

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 Total Knee 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.

Clinical Condition Requiring Homecare:

The patient is a 73-year-old male status post left total knee replacement with spinal anesthesia and has multiple comorbidities managed by his physician. Skilled nursing is ordered at a frequency of 1 week for 2 visits, and the physical therapy evaluation has been completed. The patient is alert and oriented 3, with a last fingerstick blood sugar of 156. He denies shortness of breath, and lung sounds are clear. During the visit, the patient experienced nausea with one episode of vomiting and is currently wearing an anti-nausea patch. The left knee dressing is intact, and the patient is wearing TED stockings and using a walker for safe ambulation. The spouse is assisting with all activities of daily living and instrumental activities of daily living. Skilled nursing reviewed post-operative instructions, effective pain management, and measures to manage nausea, with the patient and family verbalizing understanding. Physical therapy evaluation revealed decreased strength and range of motion following surgery, with knee extension limited to -5 degrees from neutral and flexion to 85 degrees, and muscle strength assessed at 2-/5 due to range-of-motion limitations. The patient was instructed in an initial home exercise program focusing on seated therapeutic exercises and stretching into knee flexion and extension, as well as safe ambulation with a rolling walker, emphasizing proper walker use and increased step length. The patient is able to ambulate short distances with close guarding and has initiated stair negotiation with minimal assistance. He would benefit from continued skilled physical therapy to improve strength, range of motion, mobility safety, and return to his prior level of function.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 12/09/2025
 Order<o:p></o:p> Physician Face-to-Face Date: 10/30/2025
 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left Total Knee 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<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval Notes:<o:p></o:p> Physician: Huang, James

SN Careplans

SN Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

12/09/2025

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SN WK1: 1 (12/09/25-12/13/25) ,WK2: 1 (12/14/25-12/20/25)

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, 8. Currently reports exhaustion

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.

LEFT KNEE
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, nausea/vomiting, limited range of motion, swelling of affected area, limited strength, limited endurance, Pain Interference with ADLs, balance deficit, B1000 - Vision Deficit, #1 - Non-Observable Surgical Wound - Anterior Left Knee - DRESSING INTACT

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: SN OR PT TO REMOVE LEFT KNEE DRESSING POST OP DAY 7, physician-ordered wound care: LEFT KNEE : SN/CG TO APPLY BACITRACIN TO AFFECTED AREA, COVER WITH ABD, SECURE WITH KLING AND SECURE WITH TAPE. DAILY. CG IS INDEPENDENT WITH CARE

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, 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, * 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, * how to minimize chemotherapy and radiation side-effects including management of nausea or vomiting diarrhea appetite loss hair loss fatigue insomnia, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

PATIENT-STATED GOAL: TO FEEL BETTER

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 minimize chemotherapy and radiation side-effects including management of nausea or vomiting
* diarrhea
* appetite loss
* hair loss
* fatigue
* insomnia
* recalls related medication(s) purpose, schedule

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
* 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/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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

meal preparation is available to patient for all meals

PT Careplans

PT Goals

Signature of Physician:

Date

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

Date
12/09/2025

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PT WK1: 2 (12/09/25-12/13/25) ,WK2: 2 (12/14/25-12/20/25) ,WK3: 1 (12/21/25-12/27/25) ,WK4: 1 (12/28/25-01/03/26)

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, equipment training, gait training on uneven surfaces, gai 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 - 05. Setup or clean-up assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Toilet Transfer - 05. Setup or clean-up assistance, 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, Medication Review-

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

GOALS
Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Car Transfer - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching

1 - Step (curb) - 04. Supervision or touching 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 - 05. Setup or clean-up assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Eating - 06. Independent

Sit to Stand - 04. Supervision or touching assistance

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

Toilet Transfer - 05. Setup or clean-up 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

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Medication Review-

Signature of Physician:	Date
	PAGE 4 of 4
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/09/2025