Home Health Certification and Plan of Care

Order ID: 1150/14877

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
24158895	12/12/2025	From: 12/12/2025 To: 02/09/2026	17096	217058

6. Patient's Name and Address

Joanette Jones
3044 W North Ave Apt 414,
BALTIMORE, MD 21216-
443-500-9368

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 11/23/1964 | **9.Sex** Female

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

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	12/12/25
M17.11	Unilateral primary osteoarthritis right knee	12/12/25
M16.11	Unilateral primary osteoarthritis right hip	12/12/25
M54.30	Sciatica unspecified side	12/12/25
F32.A	Depression unspecified	12/12/25
E11.65	Type 2 diabetes mellitus with hyperglycemia	12/12/25
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	12/12/25
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	12/12/25
N18.31	Chronic kidney disease stage 3a	12/12/25
M47.26	Other spondylosis with radiculopathy lumbar region	12/12/25
K64.4	Residual hemorrhoidal skin tags	12/12/25
M48.061	Spinal stenosis lumbar region without neurogenic claud	12/12/25
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	12/12/25
E66.9	Obesity unspecified	12/12/25
Z79.4	Long term (current) use of insulin	12/12/25
Z87.891	Personal history of nicotine dependence	12/12/25
Z96.642	Presence of left artificial hip joint	12/12/25

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

Sitagliptin Phosphate - Sitagliptin Phosphate 100 mg, Take 1 tablet by mouth once a day Taken1x daily for diabetes
Cymbalta - Duloxetine Hydrochloride 60 mg 60 mg, Take 1 capsule by mouth once a day Pt reports taking it for nerve pain in her legs
8-Hour Bayer - Aspirin 81mg by mouth in the morning Pt does not know med indication but takes it as instructed.
Neurontin - Gabapentin 300 mg 300 mg, Take 1 capsule by mouth three times a day Per patient; takes 1 in the morning and 2 at night
Prinivil - Lisinopril 10 mg 10 mg, Take 1 tablet by mouth once a day Taken every morning for HBP
Lipitor - Atorvastatin Calcium eq 40 mg base 40 mg, Take 1 tablet by mouth once a day Taken 1x daily for high cholesterol
Flexeril - Cyclobenzaprine Hydrochloride 10 mg, Take 1 tablet by mouth three times a day Take 1 tablet by mouth 3 times a day as needed for muscle spasms or pain
Alphacaine - Lidocaine 4 % Top PTMD Patch, Apply 1 Patch topical once a day Apply 1 Patch to skin daily as needed (pain) , may remain in place for up to 12 hours in a 24-hour period
Voltaren - Diclofenac Sodium 1 % Top Gel, Apply 4 g to affected area(s) topical four times a day Apply 4 g to affected area(s) 4 times a day as needed for pain (OTC Product)
Basaglar - Insulin Glargine 28 units subcutaneous in the morning Admistered daily for diabetes 1x daily before breakfast
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 4 hours Post surgical pain
Extra Strength Tylenol - Acetaminophen 500mg by mouth every 4-6 hours
Colace - Docusate Sodium 100mg by mouth twice a day 1-2 tabs
Ibuprofen - Ibuprofen 800 mg 1 tab by mouth three times a day For pain

14. DME and Supplies:

rolling walker, walker, diabetic supplies, bath bench

15. Safety Measures:

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

16. Nutrition:

low cholesterol, diabetic, low sodium

17. Allergies:

metformin

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: 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 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.

23. Signature and Date of Verbal SOC Where Applicable:

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

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 : 11/14/2025

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 a 61-year-old female admitted to home health services for start of care following a left total knee replacement, which currently necessitates the use of an assistive device for safety and fall prevention and makes leaving the home a taxing effort. The surgery was performed by Dr. Huang. Her past medical history is significant for osteoarthritis of the right knee and hip, prior left hip replacement, sciatica, type 2 diabetes mellitus, chronic kidney disease, spondylosis with radiculopathy, hemorrhoidal skin tags, history of diverticulitis, prior insulin use, and a history of nicotine use. On assessment, the patient was alert and oriented 3-4 and reported severe postoperative pain rated 10/10. She stated she has spoken with the surgeon and nursing staff regarding clarification of her pain management regimen, including Tylenol and prescribed oxycodone, and was instructed to set alarms to ensure timely medication administration for optimal pain control. All medications were reviewed with the patient to confirm understanding, including indications and dosing. Her most recent blood sugar was reported as 125 mg/dL, with a hemoglobin A1c of 7.0%. The patient ambulates indoors using a rolling walker for safety, completing approximately 30 feet twice with supervision and verbal cues for proper gait pattern. Transfers to the bed or sofa are performed with supervision, while bed mobility requires moderate assistance. Left knee range of motion is currently limited to approximately 0-50 degrees. The patient denies recent falls, dizziness, or lightheadedness. She reports her last bowel movement occurred the previous night, denies nausea or vomiting, and reports decreased appetite related to pain. She denies dysuria and was instructed on maintaining adequate hydration to prevent dehydration, noting that she drinks aloe vera water for hydration. Respiratory assessment revealed lungs clear to auscultation. Skin assessment showed no additional wounds; the surgical dressing to the left knee was intact, and the patient was instructed on proper dressing care, including avoiding getting the area wet or soaking it. She was educated on the use of ice therapy and anti-inflammatory medications as prescribed, as well as signs and symptoms to report immediately to the surgeon, including increased bruising, swelling, pain, or abnormal bleeding. The patient is considered homebound due to the significant effort required to leave the home, as evidenced by a Tinetti score of 12/28, indicating a high fall risk. She would benefit from skilled home therapy to address decreased strength, limited knee range of motion, impaired mobility, and functional deficits, with the goal of progressing toward improved independence. The plan includes continued skilled nursing follow-up, with a return visit scheduled to remove the dressing, assess and measure the incision site, and obtain wound photographs, as well as ongoing reinforcement of pain management, safety, and postoperative care education.
 Date of Order 12/12/2025 Orders Physician Face-to-Face Date: 11/14/2025 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 (12/12/25-12/13/25) ,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: 0. No assistance needed - patient is independent or does not have needs in this area

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.

keep incision dressing clean and dry. do not wer or soak. 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: D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, limited strength, limited range of motion, limited endurance, Pain Interference

SN Goals

PATIENT-STATED GOAL: for pain to decrease

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
* 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
* 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
* diabetic medication management
* blood sugar testing
* diabetic foot care
* exercise
* diabetic diet
* 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
* how to promote optimized mobility with strength
* balance
* dexterity
* range-of-motion therapeutic exercises

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

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with Therapy activities, balance deficit, pain radiating to arms/legs, difficulty sleeping, Pain Interference with ADLs, Pain Effect on Sleep, obesity, bruising/discoloration, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Left Knee -

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver, cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: keep incision dressing clean and dry. do not wet or soak. s/p left knee joint replacement dressing remove 7-day post-surgery dressing removed measure incision and photograph, glucose testing via monitor

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, * 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, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * how to manage symptoms of nicotine withdrawal and nicotine cravings, related medication(s) purpose, schedule, * how to promote optimized mobility with strength balance dexterity range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing prevent constipation, 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, * how to keep journal of food and fluid intake healthy meal plan tips exercise program nutritional knowledge, 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

* promotion of peripheral circulation
* fluid and diet intake to promote healing
* prevent constipation
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep journal of food and fluid intake
* healthy meal plan tips
* exercise program
* nutritional knowledge
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to manage symptoms of nicotine withdrawal and nicotine cravings
* 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 3 (12/14/25-12/20/25) ,WK3: 2 (12/21/25-12/27/25) ,WK4: 1 (12/28/25-01/03/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities

PROCEDURES: Home exercise program : Sitting knee extension, ankle pumps. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Supine hip flexion,quad sets, short arc quads, hip abduction, straight leg raise , Bed mobility training , Transfer training , Gait training , Stretching left knee 0-50 degrees

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

PT Goals

PATIENT-STATED GOAL: Ambulate independently with cane on all surfaces

GOALS
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
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	12/12/2025