Home Health Certification and Plan of Care

Order ID: 1150/15348

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
95123373	01/08/2026	From: 01/08/2026 To: 03/08/2026	20645	217058

6. Patient's Name and Address

David Barrett
3301 Luke Dr,
WESTMINSTER, MD 21157-
301-395-6481

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 09/03/1955 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	01/08/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	01/08/26
E55.9	Vitamin D deficiency unspecified	01/08/26
I70.0	Atherosclerosis of aorta	01/08/26
K64.8	Other hemorrhoids	01/08/26
E78.5	Hyperlipidemia unspecified	01/08/26
K57.30	Dvrtclos of lg int w/o perforation or abscess w/o bleeding	01/08/26
K22.70	Barrett's esophagus without dysplasia	01/08/26
K21.9	Gastro-esophageal reflux disease without esophagitis	01/08/26
R73.03	Prediabetes	01/08/26
E66.9	Obesity unspecified	01/08/26
Z68.34	Body mass index [BMI] 34.0-34.9 adult	01/08/26
Z79.82	Long term (current) use of aspirin	01/08/26
Z86.0100	Personal history of colonic polyps	01/08/26
Z85.46	Personal history of malignant neoplasm of prostate	01/08/26

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

Colace - Docusate Sodium 100 mg Oral Cap, Take 1 capsule by mouth twice a day Take 1 capsule by mouth 2 times a day
Roxicodone - Oxycodone Hydrochloride 5 mg , Take 1 to 2 tablets by mouth every 4 hours Take 1 to 2 tablets by mouth every 4 hours as needed for pain
Diltiazem - Diltiazem Hydrochloride 120 mg Oral 24hr SR Cap, Take 2 capsules by mouth once a day Take 2 capsules by mouth daily
Flomax - Tamsulosin Hydrochloride 0.4 mg Oral Cap, Take 1 capsule by mouth at bedtime Take 1 capsule by mouth daily at bedtime
Lipitor - Atorvastatin Calcium 10 mg Oral Tab, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for cholesterol and heart protection
Cozaar - Losartan Potassium 100 mg Oral Tab, Take 1 tablet by mouth once a day
Aspirin 81Mg - Aspirin 81 mg Oral TBEC DR Tab, Take 81 mg by mouth once a day Take 81 mg by mouth daily
Nystatin And Triamcinolone Acetonide - Nystatin: Triamcinolone Acetonide 100,000-0.1 unit/g-% Top Crea, apply to waist line and right arm pit topical twice a day apply to waist line and right arm pit bid prn (At Bedtime)
Omeprazole - Omeprazole 20 mg Oral CPDR SR Cap, 1 po bid x 1 week, then one po daily by mouth as necessary 1 po bid x 1 week, then one po daily
Extra Strength Tylenol - Acetaminophen Take 2 Tablets (1,000mg) by mouth every 6 hours Take 2 tablets every 6 hours as needed for mild to moderate pain rated 1-6 on numeric scale.

14. DME and Supplies:

walker, hand held shower, grab bars, cane

15. Safety Measures:

walker precautions, supervision at all times, , knee precautions, , bathroom safety, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Walker, Exercises Prescribed, 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: No

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: 3. Independent - Patient completed all the activities by

22.B.Discharge Plans

patient will be responsible for managing treatment

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 01/08/2026

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 : 12/12/2025

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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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.

Homebound status: After undergoing Right Total Knee Arthroplasty, 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 77-year-old male admitted to home health services status post right total knee arthroplasty (RTKA) performed on 01/07/2026 due to osteoarthritis. The patient reports that postoperative pain is currently well controlled. He was referred for skilled home health physical therapy secondary to postoperative pain, weakness, decreased range of motion, and impaired functional mobility. On evaluation, the patient demonstrates significant impairments in right lower extremity strength, with gross muscle strength assessed at 3-/5 and quadriceps strength at 2+/5. Left lower extremity strength is 4/5. Right knee range of motion is decreased, contributing to functional limitations and altered gait mechanics. Bed mobility requires moderate assistance due to pain and decreased control of the right lower extremity. Transfers, including sit-to-stand from a standard chair, require minimal assistance with use of bilateral upper extremities and verbal cues for proper sequencing. The patient ambulates approximately 25-40 feet indoors using a front-wheeled walker with moderate assistance. Gait is antalgic, characterized by decreased right stance time, shortened step length, and limited knee flexion during the swing phase. Balance is impaired, as evidenced by a Tinetti Balance <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">Assessment</mh> score of 13/28, indicating a high risk for falls. Skilled home health physical therapy is medically necessary to address postoperative deficits through therapeutic exercises, gait training, transfer training, balance activities, pain management strategies, and patient and caregiver education. The plan of care focuses on improving strength, range of motion, balance, gait mechanics, and functional independence while reducing fall risk and promoting safe recovery following right total knee arthroplasty. The patient is anticipated to transition safely to outpatient physical therapy services within approximately two weeks, pending continued progress.
 Date of Order 01/08/2026 Orders Physician Face-to-Face Date: 12/12/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Knee Arthroplasty 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 (01/08/26-01/10/26) ,WK2: 1 (01/11/26-01/17/26)

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.
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:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, muscle weakness, swelling of affected area, limited range of motion, limited endurance, limited strength, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Right Knee -

SN Goals

PATIENT-STATED GOAL: Patient states "I want my knee to heal without any complications."

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 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 medicatio

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

patient is adequately supervised

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/08/2026

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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 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 medicatio, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 2 (01/08/26-01/10/26) ,WK2: 2 (01/11/26-01/17/26) ,WK3: 2 (01/18/26-01/24/26)

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

PROCEDURES: Transfer Training, Gait Training, HEP: Home exercise program reviewed and progressed, including Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover. , Medication Review-: Patient verbalized understanding of current prescriptions, dosages, and schedule. No reported issues with adherence, side effects, or confusion at this time. , Equipment Training, Dynamic Standing Balance 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 relaxatio

PT Goals

PATIENT-STATED GOAL: To get to outpatient ontime

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 relaxatio

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

01/08/2026