Home Health Certification and Plan of Care

Order ID: 1150/15679

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
34148024	01/21/2026	From: 01/21/2026 To: 03/21/2026	21018	217058

6. Patient's Name and Address
Patricia Wilson
111 Highland Rd,
Glen Burnie, MD 21060-
443-994-5330

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 08/03/1964 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	01/21/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	01/21/26
M17.12	Unilateral primary osteoarthritis left knee	01/21/26
I10.	Essential (primary) hypertension	01/21/26
E78.5	Hyperlipidemia unspecified	01/21/26
K21.9	Gastro-esophageal reflux disease without esophagitis	01/21/26
K44.9	Diaphragmatic hernia without obstruction or gangrene	01/21/26
K59.09	Other constipation	01/21/26
N81.6	Rectocele	01/21/26
R73.03	Prediabetes	01/21/26
E66.9	Obesity unspecified	01/21/26
Z68.33	Body mass index [BMI] 33.0-33.9 adult	01/21/26

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

Desyrel - Trazodone Hydrochloride 50 mg, Take 1 to 2 tablets by mouth at bedtime Take 1 to 2 tablets by mouth at bedtime as needed for sleep
Norvasc - Amlodipine Besylate 10 mg, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily
Protonix - Pantoprazole Sodium 40 mg Oral TBEC DR Tab, Take 1 tablet by mouth twice a day Take 1 tablet by mouth 2 times a day
Oxaydo - Oxycodone Hydrochloride 1 Tablet (5mg) by mouth every 6 hours Take one tablet every 6 hours as needed for moderate to severe pain rated 6-10 on numeric scale.
Tylenol - Acetaminophen 2 Tablets (1, 000mg) by mouth every 6 hours Take 2 tablets every 6 hours for mild to moderate pain rated 1-5 on numeric scale. May take with Oxycodone dose in order to add to pain relief from Oxycodone.
Senna - Senna 1 Tablet (8.6mg) by mouth twice a day As needed for constipation
Docusate Sodium - Docusate Sodium 1 Tablet (100mg) by mouth twice a day Stool Softner
Aspirin 81Mg - Aspirin 01 Tablet (81mg) by mouth once a day Heart Health, HLD

14. DME and Supplies:
walker, cane

15. Safety Measures:
walker precautions, emergency phone # clearly displayed, bathroom safety, ambulates with device, transfer with assist, supervision at all times, medication safety, knee precautions, ambulates with assistance, standard precautions, fall precautions, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
meloxicam

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 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 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 61-year-old female referred from Kaiser Orthopedics following a right total knee replacement (TKR) on 1/20/26. She has no significant past medical history and returned home the same day with family assistance, who are present at all times. The patient reports well-controlled pain. The surgical dressing is dry and intact; however, the right lower extremity exhibits 2+ pitting edema from hip to ankle. Physical therapy evaluation revealed deficits including knee pain, decreased lower extremity strength, impaired functional mobility, difficulty negotiating steps, unsteady gait, decreased balance, and impaired transfers, all of which increase her risk for falls and further functional decline. The patient ambulates with a walker and requires stand-by assistance or minimal assist for bed mobility, transfers, and safe ambulation. Education was provided to the patient and caregiver regarding edema management, incision care and infection signs, fall prevention, safe transfers, bed mobility, and proper use of the walker. The patient was instructed in home exercise program activities, including supine therapeutic exercises, ankle pumps, quad sets, gluteal sets, heel slides, and range of motion exercises for the right knee, to be performed twice daily. Additional education included ice application to the knee, daily ambulation progression, and effective pain management, including timing of medications prior to therapy. A physical therapy plan of care was developed in collaboration with the patient and caregiver, and skilled home PT services are medically necessary to improve strength, balance, functional mobility, transfers, and safety awareness to restore independence. Home PT will begin 3w1 (Wed/Thu/Fri) with continued progression, and the patient is scheduled to follow up with Dr. Huang on 2/6/26.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 01/21/2026
 Order<o:p></o:p> Physician Face-to-Face Date: 01/09/2026
 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right Total Knee Replacement surgery
 Homebound Status per Certifying Physician: patient requires another person or medical equipment

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/21/2026

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 : 01/09/2026

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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such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
 1 - SOC - SN Notes:<o:p></o:p> PT Eval Notes:<o:p></o:p> Physician: Huang, James

SN Careplans

SN WK1: 1 (01/21/26-01/24/26) ,WK2: 1 (01/25/26-01/31/26)

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: 2. Non-agency caregiver(s) need training/supportive services to 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, Home Safety, M2102c - Med Admin, M1400 - Dyspnea, nausea/vomiting, limited endurance, limited strength, limited range of motion, swelling of affected area, muscle weakness, Pain Effect on Sleep, B1000 - Vision Deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, loss of appetite

PROCEDURES: Educate on wound s/sx of infection : Report increased reddness, swelling, pain, drainage, or fever greater than 100.4. , Educate when driving can resume : Driving may resume after 6 weeks. Do not take opioids and drive. , cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care: Leave Sugical dressing in place x7 days. (Aquacel/Mepilex). If drainage noted/leaking through dressing, change dressing daily to keep wound dry. RN to remove dressing on day 7. Surgical wound can be cleaned in the shower after dressing is removed. Do not soak wound. Leave wound open to air unless draining after surgical wound dressing removed. If drainage noted, cover with dry dressing. , teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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 medicatio, * 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, * 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 medic, * 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, patient's living environment is clean/uncluttered, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with

SN Goals

PATIENT-STATED GOAL: Patient states "I want my knee to heal, so that I can get my left knee replaced."

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 medic

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* 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/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

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

patient's living environment is clean/uncluttered

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/21/2026

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adequate competence

PT Careplans

PT WK1: 3 (01/21/26-01/24/26) ,WK2: 2 (01/25/26-01/31/26) ,WK3: 1 (02/01/26-02/07/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, GG0170O1 - 12 Steps, GG0130A1 - Eating, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0170P1 - Picking Up Object, GG0170F1 - Toilet Transfer, 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, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand

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: Apply ice to R knee x 20 minutes with necessary barrier and skin assessments q 5 minutes., 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 relaxatio, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: I want to be able to walk again

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

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

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

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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

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

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Sit to Stand - 06. Independent

Oral Hygiene - 06. Independent

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/21/2026