Home Health Certification and Plan of Care

Order ID: 1150/15768

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
49142032	01/18/2026	From: 01/18/2026 To: 03/18/2026	20911	217058

6. Patient's Name and Address

Donna Fabian
113 Jordan Taylor Ln,
HARWOOD, MD 20776-
443-758-3636

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 09/06/1947 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	01/18/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	01/18/26
I10.	Essential (primary) hypertension	01/18/26
M85.80	Oth disrd of bone density and structure unspecified site	01/18/26
I48.91	Unspecified atrial fibrillation	01/18/26
E78.5	Hyperlipidemia unspecified	01/18/26
K21.9	Gastro-esophageal reflux disease without esophagitis	01/18/26
H35.369	Drusen (degenerative) of macula unspecified eye	01/18/26
R73.03	Prediabetes	01/18/26
E66.9	Obesity unspecified	01/18/26
Z68.34	Body mass index [BMI] 34.0-34.9 adult	01/18/26
Z79.01	Long term (current) use of anticoagulants	01/18/26
Z90.49	Acquired absence of other specified parts of digestive tract	01/18/26
Z90.710	Acquired absence of both cervix and uterus	01/18/26
Z86.018	Personal history of other benign neoplasm	01/18/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	01/18/26
Z85.828	Personal history of other malignant neoplasm of skin	01/18/26

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

Restasis - Cyclosporine 0.05 % Opht Dropperette, Instill 1 drop in affected eye(s) drops twice a day Instill 1 drop in affected eye(s) 2 times a day
Cardizem Cd - Diltiazem Hydrochloride 120 mg Oral 24hr SR Cap, Take 1 capsule by mouth once a day Take 1 capsule by mouth daily
Pradaxa - Dabigatran Etexilate Mesylate 150 mg Oral Cap, Take 1 capsule by mouth every 12 hours Take 1 capsule by mouth every 12 hours
Lipitor - Atorvastatin Calcium 20 mg Oral Tab, Take 1 tablet by mouth once a day Take 1 tablet by mouth daily for cholesterol and heart protection
Oxycontin - Oxycodone Hydrochloride 50 Mg, Take 1 tablet by mouth every 4 hours As needed for pain
Extra Strength Tylenol - Acetaminophen 500 mg, Take 2 tablet (1,000 mg total) by mouth twice a day As needed for pain
Colace - Docusate Sodium 50 Mg, Take 1 tablet by mouth once a day Takes needed for constipation

14. DME and Supplies:
rolling walker, cane, grab bars

15. Safety Measures:
ambulates with assistance, walker precautions, knee precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
ibuprofen

18.A. Functional Limitations
None of the above

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: No

20. Prognosis: fair

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, 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 78-year-old female admitted to home health services for skilled nursing and physical therapy following a right total knee replacement performed on 01/16/2026 due to osteoarthritis and osteopenia of the right knee. The focus of skilled nursing care is postoperative monitoring and follow-up related to surgical recovery. The patient returned home on 01/17/2026 with continuous family support available. She is homebound, as leaving the home requires assistance from another person and the use of an assistive device due to impaired mobility and increased fall risk. The patient is scheduled for a postoperative follow-up with her primary care provider on 01/21/2026, an orthopedic surgeon visit on 02/06/2026, and plans to begin outpatient physical therapy on 02/09/2026. On skilled nursing assessment, the patient was alert and oriented to person, place, and time and was resting comfortably in a recliner with her husband present. She denied chest pain or respiratory discomfort and reported surgical site pain rated at 3/10, which she stated is well controlled with prescribed pain medications. The patient is compliant with pain management and is utilizing a cold therapy unit with an ice pack applied to the right knee as prescribed. Education regarding continued use of cold therapy was reinforced. Examination of the surgical site revealed a non-removable dressing that was clean, dry, and intact, with an Ace wrap in place and no evidence of abnormal bleeding, swelling, or signs of infection. The dressing is scheduled for removal on 01/24/2026. No edema was noted in the bilateral lower extremities. The patient reported constipation, stating she has not had a bowel movement in three days and is currently on a bowel regimen. Education was provided regarding bowel management, including the use of stool softeners such as Colace, hydration, and monitoring bowel habits. The patient verbalized understanding and plans to discuss bowel concerns further with her primary care provider at the upcoming appointment. Medications were reviewed in detail, with no discrepancies noted and no refills needed. Admission paperwork was completed, and the patient verbalized agreement with the established plan of care. Physical therapy evaluation revealed that following joint replacement, the patient demonstrates decreased endurance, right knee pain, decreased lower extremity strength, impaired balance, unsteady gait, difficulty with transfers and bed mobility, impaired stair negotiation, decreased safety awareness, and a history of falls, placing her at high risk for further falls and functional decline. Without skilled therapeutic intervention, the patient is at risk for loss of independence and further mobility limitations. During the physical therapy visit, the patient and caregiver were educated on the causes of postoperative edema and positional strategies to reduce swelling, including elevating the lower extremities above heart level during rest periods and the use of compression garments if recommended by the physician. Instruction was provided on recognizing signs and symptoms of infection, including fever, chills, increased redness, swelling, pain, bleeding,

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/18/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Michael O'Reilly
8008 Westpark Dr
Mclean , VA 22102
PHONE: 8007777904 FAX: NPI: 1730355447

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 : 12/31/2025

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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drainage from the surgical site, unrelieved pain, or persistent nausea or vomiting. Home safety education was completed using the patient handbook, focusing on fall risk factors, environmental hazards, and strategies to reduce fall risk within the home. The patient was instructed in safe transfer techniques using a walker, including proper hand and foot placement, forward weight shift, and reaching back to the chair prior to sitting. She required minimal assistance to standby assistance to safely complete transfers. Bed mobility training was provided with cues to improve body mechanics and promote independence, with the patient requiring minimal assistance for safe completion. Therapeutic exercises were initiated in the supine position, including ankle pumps, quadriceps sets, gluteal sets (1 set of 20 repetitions), and heel slides (1 set of 10 repetitions). A written home exercise program was provided with instructions to perform exercises twice daily. Passive range of motion of the right knee was performed in the supine position. Gait training was conducted on level surfaces using a walker, with the patient requiring standby assistance and verbal cues for appropriate positioning within the walker, increased step height and length, and overall safety. The patient was instructed to ambulate with the walker at all times. Education was provided on the importance of daily ambulation to promote circulation and prevent complications related to inactivity. The patient was instructed to initiate a walking program consisting of short walks every 1-2 hours within the home and longer walks beginning at 3-5 minutes, progressing gradually as tolerated. Pain management education was reinforced, including taking pain medication at the onset of pain, monitoring for side effects such as dizziness and constipation, and seeking immediate medical attention for chest pain, unrelieved pain, or shortness of breath. The patient was advised to take pain medication approximately one hour prior to physical therapy sessions to optimize participation. The patient verbalized understanding through teach-back. The physical therapy plan of care was discussed and developed collaboratively with the patient and caregiver, both of whom agreed with the plan. The patient will receive skilled home physical therapy beginning 01/19/2026 with a frequency of three <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> per week for one week (Monday/Tuesday/Thursday), followed by two <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> per week for one week (Tuesday/Thursday), and then one visit per week for one week (Tuesday), prior to transitioning to outpatient physical therapy on 02/09/2026. Skilled nursing will continue to monitor postoperative recovery, incision status, bowel function, pain control, medication compliance, and overall safety per the established plan of care.
 Date of Order 01/18/2026 Orders Physician Face-to-Face Date: 12/31/2025 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right 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 O'Reilly, Michael

SN Careplans

SN WK1: 2 (01/18/26-01/24/26)

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: 10. None of the above

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: M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, swelling of affected area, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, loss of appetite, #1 - Non-Observable Surgical Wound - Anterior Right Knee -

SN Goals

PATIENT-STATED GOAL: To walk without pain

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

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/18/2026

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PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Knee -, 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 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 3 (01/18/26-01/24/26) ,WK2: 2 (01/25/26-01/31/26) ,WK3: 1 (02/01/26-02/07/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170P1 - Picking Up Object, GG0130A1 - Eating, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0170F1 - Toilet Transfer, 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, 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/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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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, 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, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To walk like a normal person

GOALS
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

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

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Sit to Stand - 06. Independent

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

Oral Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/18/2026