Home Health Certification and Plan of Care

Order ID: 1150/16269

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
06081827	02/13/2026	From: 02/13/2026 To: 04/13/2026	22011	217058

6. Patient's Name and Address

Julia Fritts
702 Brookwood Rd,
BALTIMORE, MD 21229-
443-570-7623

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 09/26/1956 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	02/13/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	02/13/26
I48.0	Paroxysmal atrial fibrillation	02/13/26
F33.42	Major depressive disorder recurrent in full remission	02/13/26
G43.909	Migraine unsp not intractable without status migrainosus	02/13/26
F41.1	Generalized anxiety disorder	02/13/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	02/13/26
E78.5	Hyperlipidemia unspecified	02/13/26
J30.9	Allergic rhinitis unspecified	02/13/26
R73.03	Prediabetes	02/13/26
E66.9	Obesity unspecified	02/13/26
Z68.33	Body mass index [BMI] 33.0-33.9 adult	02/13/26
Z79.899	Other long term (current) drug therapy	02/13/26
Z79.4	Long term (current) use of insulin	02/13/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	02/13/26
Z79.82	Long term (current) use of aspirin	02/13/26
Z90.710	Acquired absence of both cervix and uterus	02/13/26
Z85.048	Prsnl hx of malig neoplm of rectum rectosig junct and anus	02/13/26

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

Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 4 hours Take 1-2 tabs Post surgical pain greater than 5
Oxygen - Oxygen 1L nasal cannula at bedtime
Pradaxa - Dabigatran Etexilate Mesylate 150 mg / capsule by mouth twice a day
Colace - Docusate Sodium 100 mg / capsule by mouth 2 times a day
Abilify - Aripiprazole 2 mg / tablet by mouth once a day
Cymbalta - Duloxetine Hydrochloride 60 mg / capsule by mouth once a day Take 2 capsules by mouth daily
Pravachol - Pravastatin Sodium 20 mg / tablet by mouth every evening Take 1 tablet by mouth every evening to prevent heart attack and stroke
Co Q 10 - Coenzyme Q10 100 mg / capsule by mouth once a day
Vitamin B Complex - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tablet by mouth once a day
METAMUCIL ORAL 1 tablet by mouth once a day
Fosamax - Alendronate Sodium 70 mg / tablet by mouth once a week Take 1 tablet by mouth every 7 days (Patient not taking: Reported on 10/17/2025)
Tylenol - Acetaminophen 500 mg / tablet by mouth as necessary Take 2 tablets by mouth every 6-8 hours as needed for pain
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000 unit / capsule by mouth once a day
Cardizem - Diltiazem Hydrochloride 120 mg / capsule by mouth once a day

14. DME and Supplies:

walker, bath bench, Raised toilet seat

15. Safety Measures:

O2 precautions, supervision at all times, standard precautions, walker precautions, knee precautions, fall precautions, bathroom safety, bleeding precautions, activity supervision, ambulates with assistance, anticoagulant precautions

16. Nutrition:

low cholesterol

17. Allergies:

levaquin

18.A. Functional Limitations

Ambulation, Endurance

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 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:

Start of care (SOC) completed for a 69-year-old patient status post left total knee replacement performed by Dr. Huang. The patient is alert and oriented 4. She reports pain rated 1/10 while standing and 5/10 while sitting. She ambulates 30 feet indoors with a rolling walker using a step-to gait pattern under supervision and performs steps with a rail and crutch with supervision. Bed mobility requires moderate assistance, and transfers to bed, chair, and toilet require supervision. Outside mobility skills and car transfers were not assessed. The patient denies falls, dizziness, lightheadedness, pain with urination, nausea, or vomiting. Last bowel movement was two days ago; bowel sounds are present. She reports tolerating small meals and was previously on a GLP-1 medication. Lungs are clear to auscultation. She uses 1 L supplemental oxygen nightly. The surgical dressing is intact, with no abnormal bleeding or additional wounds noted. The patient was instructed on hydration to prevent dehydration, proper dressing care (avoid getting the dressing wet or soaking), pain management including prescribed anti-inflammatory medications and acetaminophen (Tylenol) every 6-8 hours per revised order, and the use of ice therapy as directed. Incentive spirometer use was reviewed. The nurse will return to remove the dressing and assess, measure, and photograph the incision site. The patient was instructed to contact the surgeon immediately for increased bruising, pain, or swelling. Medications were reviewed for understanding. The patient has assistance from her brother and daughter. She is considered homebound due to significant difficulty exiting the home, as evidenced by a Tinetti score of 13/28. She would benefit from home therapy to improve range of motion and return to independence. During the visit, she tolerated quad sets, short arc quads, hip flexion, straight leg raises, hip abduction, knee extension, and ankle pumps, 10 repetitions each.<o:p></o:p> <o:p> </o:p> <o:p> </o:p> Date of Order<o:p></o:p> 02/13/2026
 Physician Face-to-Face Date: 01/09/2026
 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:<span style="font-size: 10.5pt; background-image: initial; background-position: initial; background-size: initial; background-repeat: initial; background-attachment: initial; background-origin: initial; background-clip: initial;">

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/13/2026

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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<o:p></o:p> PT Eval Notes: <o:p></o:p> Physician: Huang, James

SN Careplans

SN WK1: 1 (02/13/26-02/14/26) ,WK2: 1 (02/15/26-02/21/26)

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; 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.

S/p Left knee joint replacement surgery keep dressing clean and dry and patient instructed on nurse follow up visit
Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, constipation, limited strength, limited endurance, swelling of affected area, limited range of motion, Pain Interference with Therapy activities, balance deficit, pain radiating to arms/legs, difficulty sleeping, Pain Interference with ADLs, Pain Effect on Sleep, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Left Knee - S/p left knee joint replacement surgery

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee - S/p left knee joint replacement surgery, cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: S/p Left knee joint replacement surgery keep dressing clean and dry and patient instructed on nurse follow up visit, coordinate/arrange preparation of missing meals

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * 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

SN Goals

PATIENT-STATED GOAL: No pain and full use of left leg

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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpos

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* 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

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

02/13/2026

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PT WK1: 1 (02/13/26-02/14/26) ,WK2: 3 (02/15/26-02/21/26) ,WK3: 2 (02/22/26-02/28/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170I1 - Walk 10 Feet, 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, GG0170J1 - Walk 50 ft with 2 Turns, GG0130B1 - Oral Hygiene, 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: Home exercise program : Supine quad sets, short arc quads, hip flexion, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, equipment training, 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 - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet 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, Car Transfer - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: Be able to walk by myself without my knee buckling

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

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

Toilet Transfer - 06. Independent

Walk 150 Feet - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Car Transfer - 05. Setup or clean-up assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Walk 10 Feet - 05. Setup or clean-up assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

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

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/13/2026