Home Health Certification and Plan of Care

Order ID: 1150/16287

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
111052513	02/10/2026	From: 02/10/2026 To: 04/10/2026	21650	217058

6. Patient's Name and Address

Theresa Pugh
7909 Mine Run Road,
HANOVER, MD 21076-
301-825-4604

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 07/27/1968 | **9.Sex** Female

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

Roxicodone - Oxycodone Hydrochloride 5 mg / 1 Tablet by mouth every 4 hours take 1-2 tablets by mouth every 4 hours as needed for pain
COZAAR 100 mg / 1 Tablet by mouth once a day

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	02/10/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	02/10/26
I10.	Essential (primary) hypertension	02/10/26
E78.00	Pure hypercholesterolemia unspecified	02/10/26
K21.9	Gastro-esophageal reflux disease without esophagitis	02/10/26
E55.9	Vitamin D deficiency unspecified	02/10/26
H04.129	Dry eye syndrome of unspecified lacrimal gland	02/10/26
Z86.19	Personal history of other infectious and parasitic diseases	02/10/26
Z98.2	Presence of cerebrospinal fluid drainage device	02/10/26
Z86.79	Personal history of other diseases of the circulatory system	02/10/26
Z87.891	Personal history of nicotine dependence	02/10/26
K56.609	Unsp intestnl obst unsp as to partial versus complete obst	02/10/26
E87.6	Hypokalemia	02/10/26
D72.829	Elevated white blood cell count unspecified	02/10/26
D50.9	Iron deficiency anemia unspecified	02/10/26
I11.9	Hypertensive heart disease without heart failure	02/10/26
J45.909	Unspecified asthma uncomplicated	02/10/26
M10.9	Gout unspecified	02/10/26
Z79.51	Long term (current) use of inhaled steroids	02/10/26
Z79.82	Long term (current) use of aspirin	02/10/26

14. DME and Supplies:

bath bench, rolling walker, walker, hand held shower, 4 wheeled walker

15. Safety Measures:

walker precautions, , , , ambulates with device, ambulates with assistance, supervision at all times, transfer with assist, , knee precautions, hand rails, bathroom safety, , activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

codeine hctz hydralazine metoprolol

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

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: 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
>family/caregiver will be responsible for managing treatment

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 59-year-old female status post right total knee arthroplasty (TKA), referred for home health services following hospital discharge. Her past medical history is significant for medically managed hypertension (diagnosed 03/13/2012), presence of a ventriculoperitoneal (VP) shunt placed in June 2001 following a slow aneurysmal bleed with subsequent coil occlusion of aneurysm, history of subarachnoid hemorrhage (01/23/2017), Lyme disease (06/03/2015), gastroesophageal reflux disease (GERD) (11/07/2014), vitamin D deficiency (04/23/2014), dry eye syndrome (01/29/2009), and menopausal status. She resides in a four-level townhome with multiple flights of stairs. Her husband, who is medically complex and awaiting repeat liver and kidney transplantation with two biliary drains in place, lives in the home. A friend is currently assisting in the household. The patient works remotely as a case manager and expresses strong motivation to return to her prior level of function, including cooking, prolonged standing at the sink, and resuming normal daily activities. She is designated as full code, and all prescribed medications are present in the home. At the time of nursing admission, the patient reported severe nausea, which she attributes to oxycodone prescribed postoperatively, noting possible exacerbation of underlying gastritis symptoms. The surgical incision is covered with a dressing, with minimal drainage noted on the bandage and no signs of acute infection observed. The patient is currently ambulating with a rolling walker requiring one-person assistance and demonstrates appropriate safety awareness. The walker was assessed and adjusted to ensure approximately 20 degrees of elbow flexion for optimal biomechanics. She has expressed a desire to wean to a straight cane as soon as clinically appropriate. Gait training was initiated with walker support, emphasizing an offset step/stride pattern for safety. Step training was performed with contact guard assistance, particularly in areas without railing support. Trial training with a straight cane was initiated on stairs with contact guard assistance as needed. Education was provided regarding the potential use of tennis balls on the trailing legs of the walker to facilitate smoother ambulation within the home. Therapeutic interventions included active-assisted range of motion (AAROM) exercises for hip flexion and patellar mobilizations, manual resisted hip adduction and abduction exercises, sit-to-stand training with proper lower extremity positioning (instructed to position operative leg slightly forward during transfers), and gait training with assistive device. The patient demonstrated good recall of

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/10/2026

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 : 01/21/2026

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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transfer techniques and safety instructions. Additional education was provided on the use of incentive spirometry/inspiratory exercises, cryotherapy utilizing the Ice Man device for 20 minutes at a time (up to hourly during waking hours as tolerated), frequent skin inspection for color and temperature changes, and proper lower extremity positioning at night with ankle supported on a pillow to promote knee extension. The patient remains medically stable with well-controlled hypertension on current medication regimen. She is highly motivated, cognitively intact, and engaged in her rehabilitation program. Skilled physical therapy services are medically necessary to address postoperative deficits in strength, range of motion, balance, gait mechanics, stair negotiation, and overall functional mobility. The plan of care includes continued progression of therapeutic exercises, gait and stair training, assistive device progression as appropriate, pain and edema management, and ongoing patient education to facilitate safe return to prior level of function within a multilevel home environment. Continued monitoring of wound healing, pain control, and medication tolerance is indicated.
 Date of Order 02/10/2026 Orders Physician Face-to-Face Date: 01/21/2026 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: 3 (02/10/26-02/14/26)

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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, dependent edema, M1400 - Dyspnea, nausea/vomiting, limited strength, limited endurance, swelling of affected area, limited range of motion, muscle weakness, balance deficit, daytime fatigue, difficulty sleeping, lethargy, bruising/discoloration, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Other - right knee - Right knee TKA surgical wound

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, 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. 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., teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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

SN Goals

PATIENT-STATED GOAL: Patient states she wants to be able to walk to her mailbox again

GOALS
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

caregiver administers and/or packages medications appropriately

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/10/2026

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healthy, related medicatio, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

PT Careplans

PT WK1: 8 (02/10/26-02/14/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170P1 - Picking Up Object, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, 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: cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

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, 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 - 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: wants to be able to return to driving , accessing community resources, tolerate standing longer

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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

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

Sit to Stand - 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

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 - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/10/2026