Home Health Certification and Plan of Care

Order ID: 1150/16411

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
951039080	02/18/2026	From: 02/18/2026 To: 04/18/2026	22015	217058

6. Patient's Name and Address

Teresa Fowler
105 Stone Harbor Court,
JOPPA, MD 21085-
4102382978

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 04/21/1954 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	02/18/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	02/18/26
E03.9	Hypothyroidism unspecified	02/18/26
M85.80	Oth disrd of bone density and structure unspecified site	02/18/26
G43.909	Migraine unsp not intractable without status migrainosus	02/18/26
K21.9	Gastro-esophageal reflux disease without esophagitis	02/18/26
R73.03	Prediabetes	02/18/26
Z79.82	Long term (current) use of aspirin	02/18/26
Z79.890	Hormone replacement therapy	02/18/26
Z85.818	Prsnl hx of malig neoplm of site of lip oral cav & pharynx	02/18/26

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

PANTOPRAZOLE 40 mg Oral 2 times a day Take 1 tablet by mouth 2 times a day 30 to 60 minutes before breakfast and dinner
GABAPENTIN 300 mg by mouth three times a day Take one capsule by mouth in the morning, one capsule in the evening and two capsules at bedtime
QSYMIA 200 mg Oral 2 times a day Migraine
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, 1 to 2 tablets by mouth every 4 hours as needed for pain
Extra Strength Tylenol - Acetaminophen 500 mg, 2 tablet by mouth every 6 hours as needed for pain
Colace - Docusate Sodium 100Mg, 1 Capsule by mouth twice a day stool softner
Imitrex - Sumatriptan Succinate eq 100 mg base take 1 tablet by mouth once a day as needed for migraine
Amilodipine - Amlodipine Besylate 5mg, take 0.5 tablet by mouth once a day HTN

14. DME and Supplies:

bath bench, walker

15. Safety Measures:

ambulates with device, walker precautions, , bathroom safety, , activity supervision

16. Nutrition:

regular

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation

18.B. Activities Permitted

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
another facility/provider will be responsible for managing treatment

Homebound status: After undergoing Left 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 71-year-old female with a past medical history significant for left knee osteoarthritis status post total knee replacement, prediabetes, hypothyroidism, and osteopenia. She is currently status post left total knee arthroplasty with the surgical site covered by an intact Aquacel dressing, scheduled for removal on postoperative day seven. On assessment, the patient was alert and oriented to person, place, time, and situation (AOx4). Vital signs were within normal limits. She denied shortness of breath but reported left knee pain rated 3/10, decreased appetite, nausea, and generalized weakness. She also endorsed a loss of appetite and stated she had been unable to tolerate food intake today, although she has maintained oral fluid intake to remain hydrated. The patient's daughter reported that at approximately 6:30 a.m., while the patient was seated on the toilet, she experienced a brief syncopal episode lasting less than 10 seconds. Approximately one hour later, after attempting to eat breakfast, the patient vomited the entire meal. The daughter stated that the surgical nurse had previously contacted them to check on the patient and advised monitoring her condition and reporting any recurrence. The syncopal episode was not initially reported to the surgeon during a prior phone call. During this visit, Kaiser Hospital was contacted, and a Kaiser nurse advised that the patient proceed to the nearest emergency room for further evaluation. The patient and her daughter declined this recommendation at that time. A message was left with the surgeon's office. Subsequently, the Kaiser nurse returned the call and relayed that the surgeon declined to prescribe ondansetron (Zofran) as requested by the daughter and reiterated the recommendation for immediate evaluation in the emergency department. This information was communicated to the patient and her daughter, who stated they would contact the surgeon directly for further discussion. On physical assessment, the patient appeared weak and frail but in no acute distress. The left knee surgical dressing remained clean, dry, and intact. She was assisted with therapeutic exercises including ankle pumps, heel slides, left lower extremity abduction and adduction, straight leg raises, and long arc quadriceps exercises (10 repetitions 2 sets each). In standing position, she performed marching and heel raises (10 repetitions 2 sets). The patient ambulated to and from the bathroom using a walker with assistance and tolerated activity without acute distress. Education was reinforced regarding continued use of the ice machine to manage postoperative pain and edema, monitoring for recurrent syncope, persistent nausea or vomiting, increased pain, signs of infection, or any change in mental status. The physician was notified of the syncopal episode and associated symptoms, and the patient was strongly instructed to seek emergency evaluation as recommended. The plan includes continued close monitoring, adherence to postoperative rehabilitation exercises, maintenance of hydration, and immediate emergency evaluation if symptoms recur or worsen.
 Date of Order 02/18/2026 Orders Physician Face-to-Face Date: 02/11/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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 Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/18/2026

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 : 02/11/2026

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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SN WK1: 1 (02/18/26-02/21/26) ,WK2: 1 (02/22/26-02/28/26)

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, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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, Home Safety, M1033 - Exhaustion, M1400 - Dyspnea, nausea/vomiting, limited strength, Pain Interference with ADLs, balance deficit, loss of appetite, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Left Knee - Left knee replacement surgery

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee - Left knee replacement surgery, Medication Review: Medication reviewed with the patient/caregiver., cough/deep breathing exercises, incentive spirometer

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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient living environment has adequate lighting

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/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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

patient living environment has adequate lighting

PT Careplans

PT WK1: 2 (02/18/26-02/21/26) ,WK2: 3 (02/22/26-02/28/26) ,WK3: 1 (03/01/26-03/07/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, 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: cough/deep breathing exercises, incentive spirometer, equipment training, gait training on uneven surfaces, gait training/stair training, transfers training

PT Goals

PATIENT-STATED GOAL: To walk pain free

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

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/18/2026

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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 relaxation skills and diversional activities, related medication(s) purpose, schedule, 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, Upper Body Dressing - 06. Independent

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 relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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