Home Health Certification and Plan of Care

Order ID: 1150/17366

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
63181321	03/21/2026	From: 03/21/2026 To: 05/19/2026	20723	217058

6. Patient's Name and Address

Robin Ingraham
3 Harness Ct Apt 102,
PIKESVILLE, MD 21208-
443-682-4504

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 07/28/1955 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	03/21/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	03/21/26
M17.12	Unilateral primary osteoarthritis left knee	03/21/26
E21.0	Primary hyperparathyroidism	03/21/26
M54.16	Radiculopathy lumbar region	03/21/26
K83.8	Other specified diseases of biliary tract	03/21/26
M19.011	Primary osteoarthritis right shoulder	03/21/26
M19.012	Primary osteoarthritis left shoulder	03/21/26
J45.909	Unspecified asthma uncomplicated	03/21/26
I70.0	Atherosclerosis of aorta	03/21/26
M81.0	Age-related osteoporosis w/o current pathological fracture	03/21/26
K21.9	Gastro-esophageal reflux disease without esophagitis	03/21/26
F32.A	Depression unspecified	03/21/26
Z79.01	Long term (current) use of anticoagulants	03/21/26
Z98.84	Bariatric surgery status	03/21/26
Z86.018	Personal history of other benign neoplasm	03/21/26
Z90.49	Acquired absence of other specified parts of digestive tract	03/21/26
Z86.711	Personal history of pulmonary embolism	03/21/26
Z86.718	Personal history of other venous thrombosis and embolism	03/21/26
Z85.3	Personal history of malignant neoplasm of breast	03/21/26
Z87.891	Personal history of nicotine dependence	03/21/26

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

Toprol Xl - Metoprolol Tartrate 25 mg Oral 24hr SR Tab / 1 Tablet by mouth once a day
Roxicodone - Oxycodone Hydrochloride 5 mg / 1 Tablet by mouth every 4 hours Take 1 to 2 tablets as needed for pain
Benadryl - Diphenhydramine Hydrochloride 25 mg / 1 Capsule by mouth at bedtime as needed
Adderall Xr - Amphetamine Aspartate: Amphetamine Sulfate: Dextroamphetamine Saccharate: Dextroamphetamine Sulfate 15 mg Oral 24hr SR Cap / 1 Capsule by mouth in the morning
CALCIUM 600 WITH VITAMIN D3 (Calcium Carbonate-Vit D3) 600 mg-12.5 mcg (500 unit) Oral Cap / 1 Capsule by mouth twice a day with meals
Lidocaine Patch - Lidocaine (LIDOCAINE PAIN RELIEF) 4 % Top PTMD Patch / 1 Patch topical once a day
Pepcid - Famotidine 20 mg / 1 Tablet by mouth twice a day
Effexor Xr - Venlafaxine Hydrochloride eq 75 mg base / 1 Capsule by mouth once a day Take 3 capsules daily
Lipitor - Atorvastatin Calcium eq 40 mg base / 1 Tablet by mouth once a day for cholesterol and heart protection
Galzin - Zinc Acetate eq 50 mg zinc / 1 Capsule by mouth once a day
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 25 mcg (1,000 unit) Oral Tab / 1 Tablet by mouth once a day
Magnesium Oxide - Simethicone 400 mg (241.3 mg magnesium) / 1 Tablet by mouth once a day
VITRON-C ORAL (iron,carbonyl/ascorbic acid) - by mouth once a day
Neurontin - Gabapentin 400 mg 400 mg / 1 Capsule by mouth once a day 2 tablets, 800 mg total
Warfarin - Warfarin Sodium 0 1 mg / 2-2.5 tablets by mouth as necessary 2.5 tablets every day, but 2 tablets on Fridays
Desyrel - Trazodone Hydrochloride 50 mg **federal register determination that product was not discontinued or withdrawn for safety or efficacy reason** 50 mg **federal register determination that product was not discontinued or withdrawn for safety or efficacy reason** / 1 Tablet by mouth at bedtime Not taking until oxycodone is discontinued

14. DME and Supplies:

walker, grab bars

15. Safety Measures:

walker precautions, medication safety, fall precautions, ambulates with assistance, ambulates with device

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

Aspirin Morphine Tamoxifen Milk NSAIDS Non-Selective (Non-Steriodal Anti Infl

18.A. Functional Limitations

Ambulation

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: fair

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 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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 03/21/2026

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 : 03/11/2026

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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Clinical Condition Requiring Homecare:

The patient is a 70-year-old female, alert and oriented, residing with a roommate in a single-level apartment, referred to home health services following a right total knee arthroplasty (TKA). Her past medical history includes arthritis, gastric bypass, depression, GERD, and breast cancer. The right knee incision is covered with a Mepilex dressing to remain in place until seven days post-surgery. Prior to surgery, she ambulated independently without an assistive device, occasionally using a single-point cane. On physical therapy evaluation, she demonstrates decreased strength in the right lower extremity (2-/5 MMT) and range-of-motion deficits, with -5 degrees of extension and 80 degrees of flexion. She requires contact guard assistance for transfers and short-distance ambulation with a rolling walker, with focus on improving trunk extension and step length. The patient was instructed in an initial home exercise program emphasizing seated therapeutic exercises for knee flexion and extension. Skilled physical therapy services are recommended to improve strength, range of motion, and safe mobility to facilitate return to her prior level of function.<o:p></o:p> <o:p> </o:p> Date of Order<o:p></o:p> 03/21/2026
 Physician Face-to-Face Date: 03/11/2026
 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 such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>
 1 - SOC - SN Notes:
 PT Eval 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;"><o:p></o:p> Physician: Huang, James

SN Careplans

SN WK1: 1 (03/21/26-03/21/26) ,WK2: 1 (03/22/26-03/28/26)

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

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:POLST (Physician Orders for Life-Sustaining Treatment)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M1400 - Dyspnea, heartburn/indigestion, poor muscle tone, muscle weakness, limited range of motion, Pain Effect on Sleep, Pain Interference with ADLs, loss of appetite, bruising/discoloration, #1 - Non-Observable Surgical Wound - Other - Right knee - Non observable due to non removable dressing

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Right knee - Non observable due to non removable dressing, apply anti-embolitic stockings, wound vacuum, home exercise program

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 medication(s) purpose, schedule, * 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound

SN Goals

PATIENT-STATED GOAL: I want to be pain free

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 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

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) 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 medication(s) purpose, schedule

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

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/21/2026

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

PT Careplans

PT WK2: 3 (03/22/26-03/28/26) ,WK3: 3 (03/29/26-04/04/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170J1 - Walk 50 ft with 2 Turns, 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, GG0130B1 - Oral Hygiene, GG0170I1 - Walk 10 Feet, 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: Medication Review: - medications reviewed with patient/caregiver, cough/deep breathing exercises, home exercise program: Knee ext, quad sets, gluteal squeezes 1x10, upgrade as tolerated, equipment training, 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 relaxation skills and diversional activities, related medication(s) purpose, schedule, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 05. Setup or clean-up assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 02. Substantial/maximal assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Medication Review

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain

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

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

Toilet Transfer - 05. Setup or clean-up assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up 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 relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

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

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Oral Hygiene - 05. Setup or clean-up assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 02. Substantial/maximal assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Medication Review

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/21/2026