Home Health Certification and Plan of Care

Order ID: 1150/18619

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
45195623	05/12/2026	From: 05/12/2026 To: 07/10/2026	25082	217058

6. Patient's Name and Address
Tanya Latham
2107 Allendale Rd,
Baltimore, MD 21216-
443-531-5952

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 03/08/1961 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	05/12/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	05/12/26
M17.11	Unilateral primary osteoarthritis right knee	05/12/26
M51.369	Oth intvrt disc degen lum rgn w/o lum bck or lw extrm painOth intvrt disc degen lum rgn w/o lum bck or lw extrm pain	05/12/26
I70.0	Atherosclerosis of aorta	05/12/26
E78.5	Hyperlipidemia unspecified	05/12/26
I10.	Essential (primary) hypertension	05/12/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/12/26
M85.80	Oth disrd of bone density and structure unspecified site	05/12/26
E04.2	Nontoxic multinodular goiter	05/12/26
R91.1	Solitary pulmonary nodule	05/12/26
H35.033	Hypertensive retinopathy bilateral	05/12/26
E66.9	Obesity unspecified	05/12/26
Z68.32	Body mass index [BMI] 32.0-32.9 adult	05/12/26
Z79.82	Long term (current) use of aspirin	05/12/26
Z79.891	Long term (current) use of opiate analgesic	05/12/26
Z86.0100	Personal history of colonic polyps	05/12/26
Z87.891	Personal history of nicotine dependence	05/12/26

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

ECOTRIN Delayed Release 81 mg / 1 Tablet by mouth 2 times a day
COLACE 100 mg / 1 Capsule by mouth 2 times a day
NORVASC 5 mg / 1 Tablet by mouth daily
LIPITOR 10 mg / 1 Tablet by mouth daily for cholesterol and heart protection
FEROSUL 325 mg (65 mg iron) / 1 Tablet by mouth daily
Triamterene-hydroCHLOROthiazide (MAXZIDE-25MG) 37.5-25 mg Oral Tab 25 MG mg by mouth daily
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg=1tablet by mouth every 4 hours As needed

14. DME and Supplies:
walker

15. Safety Measures:
walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with device, medication safety, knee precautions, standard precautions, fall precautions, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Transfer bed/Chair, Walker, 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: 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
family/caregiver will be responsible for managing treatment

Homebound status: After undergoing Left 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: Home health skilled nursing admission was completed for a 65-year-old female referred to home health services status post left total knee replacement. Past medical history is significant for osteoarthritis, obstructive sleep apnea, hyperlipidemia, thrombocytosis, and atherosclerosis of the aorta. Upon assessment, the patient was alert and oriented, at home, and in stable condition without signs of acute distress. Surgical dressing to the left knee was intact with no drainage noted. Mild postoperative swelling was observed to the surgical extremity. Skilled nursing education was provided regarding swelling prevention and management, including proper elevation of the extremity, application of ice as ordered, adherence to prescribed therapy, and monitoring for complications such as increased swelling, redness, drainage, or worsening pain. The patient currently denied pain during the visit; however, comprehensive education was provided regarding prescribed pain management, including appropriate use of oxycodone, medication compliance, potential side effects, fall precautions, and nonpharmacological pain relief strategies. Additional teaching included signs and symptoms of infection, deep vein thrombosis (DVT) prevention, safe ambulation techniques, and instructions on when to notify the physician or home health agency of any concerns. The patient verbalized understanding of all education provided. The patient resides with her grandson in a townhouse requiring negotiation of nine steps with railing access to enter the home. Bedroom and bathroom are located on the second floor with only a partial handrail available. Functional mobility assessment revealed the patient ambulates approximately 30 feet indoors using a rolling walker with verbal cues required for step-to gait pattern and reduced gait speed for safety. The patient was able to negotiate 14 stairs using a handrail and cane with close supervision, leaning against the wall for support when railings were unavailable. Bed mobility and transfers from bed, chair, and toilet were completed with supervision. Outside ambulation and car transfer abilities were not assessed during this visit. The patient is considered homebound due to the significant and taxing effort required to leave the home, compounded by impaired mobility, postoperative weakness, pain risk, decreased balance, and fall risk as evidenced by a Tinetti Balance Assessment score of 13/28. Therapeutic exercises performed and tolerated during the visit included 10 repetitions each of seated knee extensions, ankle pumps, supine hip flexion, quad sets, short arc quads, straight leg raises, and hip abduction exercises. Skilled home health physical therapy is medically necessary to improve lower extremity strength, range of motion, gait mechanics, stair negotiation, balance, and overall functional mobility in order to maximize safety and facilitate return to prior level of independence within the home environment.
 Date of Order 05/12/2026 Orders Physician Face-to-Face Date:

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/12/2026

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 : 04/15/2026

27. Attending Physician's Signature and Date Signed **05/18/2026**: 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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04/15/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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 Huang, James

SN Careplans

SN WK1: 1 (05/12/26-05/16/26) ,WK2: 1 (05/17/26-05/23/26)

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:No

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, M2102f - Patient Supervision, meal preparation, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, limited range of motion, limited endurance, limited strength, balance deficit, Pain Effect on Sleep, Pain Interference with ADLs, B1000 - Vision Deficit, #1 - Non-Observable Surgical Wound - Anterior Left Knee -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee -, cough/deep breathing exercises, incentive spirometer, teach/coordinate/arrange medication packaging and/or administration, 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 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: Heap without difficulty;Heal without difficulty

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
* 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/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

patient's transportation needs are met

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

05/12/2026

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PT WK1: 3 (05/12/26-05/16/26) ,WK2: 3 (05/17/26-05/23/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, 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, GG0170I1 - Walk 10 Feet, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Bed mobility training : Sit to supine, Medication reconciliation : Any medication changes, Assess left knee incision with bandage or without bandage: After bandage is removed in 7 days- Measure incision, Self stretching left knee into flexion: 5x hold 10 seconds, 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 relaxation skills and diversional activities, related medication(s) purpose, schedule, 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 - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 05. Setup or clean-up assistance, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: To be able to get around the house by myself without a cane

GOALS
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
* 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 - 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

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

Car Transfer - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Upper Body Dressing - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

Lower Body Dressing - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate assistance

Eating - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/12/2026