Home Health Certification and Plan of Care

Order ID: 1150/18936

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
94246470	05/23/2026	From: 05/23/2026 To: 07/21/2026	25556	217058

6. Patient's Name and Address

Brenda Neal
125 Dunlap Rd,
PASADENA, MD 21122-
410-360-4085

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 09/23/1945 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	05/23/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	05/23/26
M81.0	Age-related osteoporosis w/o current pathological fracture	05/23/26
D80.2	Selective deficiency of immunoglobulin A [IgA]	05/23/26
N32.81	Overactive bladder	05/23/26
I70.0	Atherosclerosis of aorta	05/23/26
E78.5	Hyperlipidemia unspecified	05/23/26
H04.123	Dry eye syndrome of bilateral lacrimal glands	05/23/26
D69.2	Other nonthrombocytopenic purpura	05/23/26
K44.9	Diaphragmatic hernia without obstruction or gangrene	05/23/26
N95.8	Other specified menopausal and perimenopausal disorders	05/23/26
R73.03	Prediabetes	05/23/26
F41.9	Anxiety disorder unspecified	05/23/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/23/26
Z86.16	Personal history of COVID-19	05/23/26
Z86.0100	Personal history of colonic polyps	05/23/26
Z85.820	Personal history of malignant melanoma of skin	05/23/26

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

NEURONTIN 300 mg 300 mg / 1 Capsule by mouth in the evening for 5 days then twice daily for 5 days then 1 capsule 3 times daily. Increase dose every 5 days as directed
LIPITOR 10 mg / 1 Tablet by mouth two times per week For cholesterol and heart protection (Patient not taking: Reported on 4/26/2026)
PEPCID 40 mg 40 mg / 1 Tablet by mouth daily at bedtime
Sodium Chloride - Sodium Chloride 1,000 mg / 1 Tablet by mouth twice a day
Melatonin - Melatonin 10mg by mouth at bedtime 1-2 tabs for insomnia
Extra Strength Tylenol - Acetaminophen 500mg by mouth as necessary Pain
Aspirin 81Mg - Aspirin 81mg by mouth twice a day For 3o days

14. DME and Supplies:

walker

15. Safety Measures:

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

16. Nutrition:

low cholesterol

17. Allergies:

doxycycline amoxicillin with clavulanate potassium cipro metronidazole

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: 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

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:

The patient is an 80-year-old female who is status post left total knee replacement (LTKR) performed on 05/21/2026 by Dr. Huang and was referred to home health services for skilled nursing and physical therapy following hospital discharge. The patient is homebound due to postoperative pain, decreased mobility, impaired endurance, and increased fall risk, requiring the use of a front-wheeled walker and assistance from another person for safe ambulation and community access. Leaving the home requires considerable and taxing effort. Upon assessment, the patient was alert and oriented 4 and residing at home with her husband, who is available to assist with care as needed. The patient reported postoperative left knee pain ranging from 7/10 to 8/10. She is currently taking acetaminophen for pain management and was instructed not to exceed 3,000 mg daily. The patient reported intolerance to oxycodone, stating it caused significant nausea and vomiting during hospitalization; therefore, she declined further use of this medication. She expressed that ibuprofen had been effective for inflammation and pain control in the past. Skilled nursing contacted the Kaiser Permanente nurse advice line to request consideration of an alternative anti-inflammatory medication, and a message was forwarded to Dr. Huang through his representative, Karen. The patient denied any current nausea, vomiting, dizziness, lightheadedness, urinary discomfort, abnormal bleeding, or recent falls. Appetite remains decreased but is gradually improving. Last bowel movement occurred the day prior to assessment. Physical assessment revealed postoperative bruising and swelling of the left lower extremity consistent with expected surgical findings. Surgical dressing remained intact with instructions reinforced to keep the dressing clean, dry, and intact and to avoid soaking or wetting the surgical site. No additional wounds were noted. Lung sounds were clear to auscultation bilaterally, and the patient demonstrated proper use of the incentive spirometer following review and reinforcement of respiratory exercises. The patient is currently prescribed aspirin 81 mg twice daily for thromboprophylaxis and was educated regarding <hility is-highlighty="true" role="mark" data-hility="93032137-0230-4c13-a00b-e29ab027a8f4" data-hility-name="bleeding precautions" data-hility-match="highlight-pass-53:1" data-decoration-type="background" style="--decoration-thickness: auto;">bleeding precautions</hility> and signs of potential complications. Medication reconciliation was completed, and all medications were reviewed with the patient to ensure understanding of indications, dosages, frequencies, and potential side effects. Skilled nursing provided extensive education regarding pain management strategies, including medication use as prescribed, ice therapy application, edema management, hydration to prevent dehydration, recognition of infection signs and symptoms, and indications for contacting the surgeon immediately, including increased pain, swelling, redness, drainage, bruising, fever, or other concerning changes. The patient verbalized understanding of all teaching provided. Physical therapy evaluation was completed. The patient presents with postoperative left knee pain, decreased lower extremity strength, impaired balance, decreased endurance, difficulty with transfers, unsteady gait, impaired stair negotiation, reduced functional mobility, and increased risk for falls. Transfer training was initiated with instruction on proper hand placement, weight shifting, and safe use of the walker during sit-to-stand and stand-to-sit activities, requiring minimal assistance to standby assistance. Bed mobility training was also provided with emphasis on proper body mechanics and

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 05/23/2026

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 : 05/12/2026

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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safety techniques, requiring minimal assistance. The patient was instructed in and performed an initial home exercise program consisting of ankle pumps, quadriceps sets, gluteal sets, and heel slides, with written instructions provided and recommendations to perform exercises twice daily. Passive range-of-motion exercises were also performed to improve joint mobility. Gait training was initiated using a walker on level surfaces with standby assistance, emphasizing appropriate walker positioning, improved step length, foot clearance, and overall safety. Education was provided regarding the importance of frequent ambulation, gradual activity progression, edema reduction through lower extremity elevation, use of ice therapy for 20-minute intervals with skin monitoring, and fall prevention strategies within the home environment. The patient demonstrates good rehabilitation potential and is expected to benefit from continued skilled nursing and physical therapy services to address pain management, postoperative monitoring, strength deficits, gait abnormalities, transfer safety, balance impairments, functional mobility limitations, and fall prevention. Ongoing services are medically necessary to promote healing, maximize independence, facilitate return to prior level of function, and reduce the risk of complications, falls, and rehospitalization. The patient and caregiver participated in development of the plan of care and are in agreement with all recommended services and interventions.
 Date of Order 05/23/2026 Orders Physician Face-to-Face Date: 05/12/2026 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 (05/23/26-05/23/26) ,WK2: 1 (05/24/26-05/30/26)

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.

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.
Advance Directive:Na

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, abdominal pain, nausea/vomiting, swelling of affected area, limited range of motion, Pain Effect on Sleep, Pain Interference with ADLs, Pain Interference with Therapy activities, balance deficit, loss of appetite, #1 - Non-Observable Surgical Wound - Anterior Left Knee - , red/tender pressure points, swell/redness surround. skin

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee -, cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, 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., coordinate/arrange for adequate patient supervision, coordinate/arrange preparation

SN Goals

PATIENT-STATED GOAL: Not stiffen up and increase range of motion

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 medication(s) purpose, schedule

caregiver performs medical/rehabilitation treatments with adequate competence

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

patient is adequately supervised

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/23/2026

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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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK2: 1 (05/24/26-05/30/26) ,WK3: 3 (05/31/26-06/06/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170P1 - Picking Up Object, GG0130F1 - Upper Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170D1 - Sit to Stand, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer

PROCEDURES: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ, hip flex, seated heel slides, operated knee flex with opposite LE assist Standing-Mini squat, heel/toe raise, hip flex, leg curls, operated leg up down on 1st step, 1st step lunge with quad set on extension., therapeutic modalities: apply ice to L knee x 20 minutes with necessary barrier and skin assessments q 5 minutes., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching 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, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To be able to get back to dancing

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

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

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

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	05/23/2026