Home Health Certification and Plan of Care

Order ID: 1150/19190

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
89272364	06/03/2026	From: 06/03/2026 To: 08/01/2026	2179	217058

6. Patient's Name and Address

Angela Christian
2409 Arunnah Ave,
BALTIMORE, MD 21216-
443-520-0281

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 07/12/1959 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	06/03/26

13. ICD	Other Pertinent Diagnoses	Date
G40.909	Epilepsy unsp not intractable without status epilepticus	06/03/26
I10.	Essential (primary) hypertension	06/03/26
H90.3	Sensorineural hearing loss bilateral	06/03/26
E55.9	Vitamin D deficiency unspecified	06/03/26
J38.1	Polyp of vocal cord and larynx	06/03/26
M85.80	Oth disrd of bone density and structure unspecified site	06/03/26
Q89.01	Asplenia (congenital)	06/03/26
H81.10	Benign paroxysmal vertigo unspecified ear	06/03/26
R73.03	Prediabetes	06/03/26
H81.09	Meniere's disease unspecified ear	06/03/26
E66.01	Morbid (severe) obesity due to excess calories	06/03/26
Z68.38	Body mass index [BMI] 38.0-38.9 adult	06/03/26
Z79.51	Long term (current) use of inhaled steroids	06/03/26
Z79.82	Long term (current) use of aspirin	06/03/26
Z96.653	Presence of artificial knee joint bilateral	06/03/26
Z87.891	Personal history of nicotine dependence	06/03/26

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

Atorvastatin (lipitor) 40mg, 1 tablet by mouth once a day For cholesterol and heart protection
Asa 81 Mg - Aspirin 1 tab by mouth twice a day
losartan (Cozaar) 100mg, 1 tablet by mouth once a day
Keppra - Levetiracetam 100 mg/ml 100mg/ml, take 10 ml by mouth twice a day
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 1 tab by mouth every 4 hours as needed for pain
Tylenol Es 500 Mg - Acetaminophen 500mg; 1-2 tabs by mouth every 8 hours as needed for pain
Naproxen - Naproxen 500 mg 500mg=1tablet by mouth as necessary 1 tablet daily
Amilodipine - Amlodipine Besylate 5mg=1tablet by mouth once a day
Colace - Docusate Sodium 100mg=1tablet by mouth twice a day
Benadryl - Diphenhydramine Hydrochloride 10 mg/ml 1 tab by mouth once a day

14. DME and Supplies:

walker, hand held shower

15. Safety Measures:

walker precautions, smoke detectors , seizure precautions, , bathroom safety, ambulates with device, medication safety, knee precautions, standard precautions, fall precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

Levonorgestrel-Ethinyl Estrad

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

family/caregiver will be responsible for managing treatment
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: Patient is a 64-year-old female admitted to home health services following recent left total knee replacement surgery. Her past medical history is significant for epilepsy, hypertension, osteoarthritis, cardiovascular disease, prior right knee replacement, sciatica, and a history of right ankle fracture. During her postoperative recovery period, the patient is temporarily residing with her mother in a row house with seven steps required for entry and bedroom and bathroom access located on the second floor. Her mother provides assistance with activities of daily living, medication management, and overall care needs as needed. Comprehensive assessment was completed during today's visit. Patient was alert and oriented to person, place, time, and situation (A&O 4). Vital signs were stable and within normal limits. The patient ambulates with a rolling walker and currently demonstrates limited mobility secondary to recent left knee surgery. Gait assessment revealed the patient was able to ambulate approximately 30 feet twice on indoor surfaces with supervision and verbal cueing for proper gait pattern and safety. Bed mobility was completed with supervision, and the patient performed transfers to bed, chair, and toilet with supervision. Stair negotiation, outdoor mobility, and car transfer assessments were not performed during this visit. The patient is considered homebound due to the significant effort required to leave the home and an increased fall risk, as evidenced by a Tinetti Balance and Gait Assessment score of 13/28. Assessment of the surgical site revealed the left knee dressing to be clean, dry, and intact. Mild swelling was noted in the left lower extremity. No redness, drainage, increased warmth, or other signs and symptoms of infection were observed. Range of motion assessment of the left knee demonstrated 10 degrees of extension deficit and flexion to 110 degrees. Limited knee extension, postoperative pain, weakness, and impaired mobility continue to impact the patient's functional performance and safety. Medication reconciliation was completed with no discrepancies identified. Skilled nursing education was provided regarding postoperative care, medication management, including medication purpose, dosage, administration, and potential side effects. Additional teaching focused on pain management strategies, including the use of prescribed medications, non-pharmacological pain relief techniques, and the importance of promptly reporting uncontrolled pain or adverse medication effects. Education was also provided regarding swelling prevention measures, including elevation of the affected extremity, adherence to physician-ordered activity restrictions, fall prevention strategies, and recognition of signs and symptoms of infection or other postoperative complications requiring physician notification. Patient and caregiver verbalized understanding of all instructions provided. Skilled nursing services remain medically necessary for ongoing assessment of surgical wound healing, monitoring for postoperative complications and infection, pain assessment and management, medication management, reinforcement of disease process and postoperative education, and continued patient and caregiver instruction to promote safe recovery, maximize functional outcomes, and prevent rehospitalization. Continued skilled therapy services are indicated to improve lower extremity strength, range of motion, gait quality, balance, transfer ability, stair negotiation, and overall functional independence.
 Date of Order 06/03/2026 Orders Physician Face-to-Face Date:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/03/2026

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 : 05/13/2026

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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05/13/2026 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 (06/03/26-06/06/26) ,WK2: 1 (06/07/26-06/13/26)

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 Advance Directive

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, B0200 - Hearing Deficit, Pain Effect on Sleep, Pain Interference with ADLs, B1000 - Vision Deficit, #1 - Non-Observable Surgical Wound - Other - Left knee -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Left knee -, cough/deep breathing exercises, incentive spirometer, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals, coordinate/arrange resources for vision-impaired, coordinate/arrange home modifications for hearing impaired, i.e. alarms

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 hearing-impaired including installing special fire-detector/CO2 alarms, 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: Patient stated she would like to heal properly from surgery 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 keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* 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 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
* 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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/03/2026

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PT Careplans

PT WK1: 2 (06/03/26-06/06/26) ,WK2: 3 (06/07/26-06/13/26) ,WK3: 1 (06/14/26-06/20/26)

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, GG0170G1 - Car Transfer, GG0170D1 - Sit to Stand, 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

PROCEDURES: Stretching to left knee initially 10-110 degrees.: 5x into extension and flexion, home exercise program: 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: 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 - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To walk straight by myself and go back to my house

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

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

Toilet Transfer - 06. Independent

Walk 150 Feet - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Car Transfer - 05. Setup or clean-up assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

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

Shower/Bathe Self - 02. Substantial/maximal 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

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

06/03/2026