Home Health Certification and Plan of Care

Order ID: 1150/19432

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
81207054	06/03/2026	From: 06/03/2026 To: 08/01/2026	25846	217058

6. Patient's Name and Address

Bonnie Brill
1202 Swallow Ct,
HALETHORPE, MD 21227-
410-241-4957

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 07/30/1950 **9.Sex** Female

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

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	06/03/26
I10.	Essential (primary) hypertension	06/03/26
F32.A	Depression unspecified	06/03/26
E78.5	Hyperlipidemia unspecified	06/03/26
F41.9	Anxiety disorder unspecified	06/03/26
E61.1	Iron deficiency	06/03/26
K21.9	Gastro-esophageal reflux disease without esophagitis	06/03/26
R73.03	Prediabetes	06/03/26
Z87.891	Personal history of nicotine dependence	06/03/26
Z87.11	Personal history of peptic ulcer disease	06/03/26
Z90.710	Acquired absence of both cervix and uterus	06/03/26
Z96.643	Presence of artificial hip joint bilateral	06/03/26

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

DESYREL 50 mg/tablet / Take half tablet by mouth once a day at bedtime
LEXAPRO 20 mg / 1 Tablet by mouth daily
LIPITOR 80 mg / 1 Tablet by mouth daily for cholesterol
FOSAMAX 70 mg / 1 Tablet by mouth every week Take in the morning with 8 ounces of water at least 30 minutes before the first food, drink or other medication of the day. Do not lie down for at least 30 minutes after swallowing this medication
PROTONIX Delayed Release 40 mg / 1 Tablet by mouth 30 to 60 minutes prior to a meal
ASTELIN 137 mcg (0.1 %) Nasl Spray / Use 2 Sprays in each nostril Nasal twice a day Use everyday, do not skip days.
CALCIUM ORAL
MULTIVITAMIN Oral
NIZORAL 2 % Top Shampoo / Apply to affected area(s) topical two times per week Use as shampoo
Kenalog - Triamcinolone Acetonide 0.1 % Top Ointment topical Apply to affected area(s) 2 times a day For 2 weeks then 1 week off, as needed

14. DME and Supplies:

wound care supplies, walker, small base cane, grab bars, hand held shower, commode, cane, bath bench

15. Safety Measures:

walker precautions, transfer with assist, standard precautions, smoke detectors , medication safety, knee precautions, hand rails, fall precautions, bathroom safety, aspiration precautions, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

augmentin iv contrast

18.A. Functional Limitations

Ambulation, Endurance

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: Yes

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

Homebound status: After undergoing Right 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 75-year-old female who is one day status post right total knee replacement (RTKR) performed on 06/02/2026. The patient returned home the same day following surgery and currently resides with her husband, who provides continuous assistance and support during her recovery. The patient also reports having supportive family members and neighbors nearby who are available to assist with daily needs as needed. Due to postoperative limitations, the patient is currently sleeping in the living area and utilizing a bedside commode positioned adjacent to her bed to reduce the need for excessive ambulation and improve safety. During the skilled nursing assessment, the patient reported right lower extremity and right knee pain related to recent surgery but stated that pain is being adequately managed with prescribed pain medications and use of the IceMan cold therapy system as directed by the surgeon. The patient verbalized understanding of her medication regimen and how to take all prescribed medications appropriately. She reported that her physician recently instructed her to decrease her blood pressure medication dosage, with the adjustment beginning on the day of assessment. Vital signs were stable and within normal limits. The patient demonstrated understanding of all postoperative instructions provided by the surgical team and reported an upcoming follow-up appointment with her orthopedic surgeon, although the exact date was not available at the time of the visit. Home safety education was reinforced, including recommendations to keep household dogs away from the surgical incision and to remove dog training pads due to their lack of non-slip backing and associated fall risk. The patient verbalized understanding and denied additional questions or concerns. The patient is considered homebound due to recent right total knee replacement, postoperative pain, decreased endurance, impaired mobility, and increased fall risk. She requires the assistance of another person and the use of a walker to safely leave the home. Physical therapy evaluation was completed and revealed significant postoperative functional limitations, including right knee pain, decreased right lower extremity strength, reduced functional mobility, difficulty negotiating stairs, unsteady gait, impaired transfers, decreased balance, decreased safety awareness, and an increased risk for falls. These deficits significantly impact the patient's ability to safely perform activities of daily living and mobility-related tasks and place her at risk for further functional decline and loss of independence without skilled intervention. A comprehensive physical therapy plan of care was established and reviewed with the patient and caregiver, both of whom agreed with the proposed treatment plan. The patient is scheduled to receive home physical therapy beginning 06/03/2026 and is expected to transition to outpatient physical therapy on 06/18/2026. Follow-up with Physician Assistant Hans is scheduled for 06/17/2026. Skilled physical therapy interventions initiated during the evaluation included instruction in edema management and positioning strategies to reduce swelling, including lower extremity elevation above heart level during rest periods and use of compression garments if recommended by the physician. Education was also provided regarding signs and symptoms of infection, including fever, chills, redness, swelling, increased pain, bleeding, drainage from the surgical site, persistent nausea or vomiting, and pain unrelieved by medication. Fall prevention and home safety education were reviewed in accordance with the patient handbook, focusing on environmental modifications and strategies to reduce fall risk within the home. Transfer training was completed using a walker with instruction regarding proper hand placement, foot positioning, forward weight shift, and reaching back prior to sitting. The patient required standby assistance to safely complete transfers. Therapeutic exercises were initiated and included supine ankle pumps, quadriceps sets, gluteal sets (1 set of 20 repetitions each), and heel slides (1 set of 10 repetitions). Passive range of motion exercises were also performed to the right knee in the supine position. A written home exercise program was provided, and the patient was instructed to perform the exercises twice daily. Gait training was completed on level surfaces using a walker. The patient required standby assistance and verbal cueing for proper positioning within the walker, increased bilateral step height and step length, and overall safety

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 : 05/20/2026

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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during ambulation. She was instructed to use the walker at all times during mobility activities. Education was also provided regarding the importance of daily ambulation to promote circulation, prevent complications associated with inactivity, and support postoperative recovery. The patient was instructed to initiate a walking program consisting of short walks within the home every 1-2 hours and gradually progress to longer walks beginning at 3-5 minutes as tolerated. Additional education focused on pain management strategies, including taking pain medication at the onset of pain, monitoring for potential side effects such as dizziness and constipation, and applying ice to the right knee for 20-minute intervals with appropriate skin protection and skin assessments every five minutes. The patient was instructed to contact emergency medical services or her healthcare provider for chest pain, shortness of breath, uncontrolled pain, or other concerning symptoms. She was also advised to take pain medication approximately one hour prior to physical therapy sessions to optimize participation. The patient demonstrated understanding of all education provided through teach-back. Skilled nursing and physical therapy services remain medically necessary for ongoing postoperative monitoring, pain management, edema control, gait and transfer training, therapeutic exercise progression, balance training, fall prevention, patient and caregiver education, and restoration of safe functional mobility and independence following right total knee replacement.
 Date of Order 06/03/2026 Orders Physician Face-to-Face Date: 05/20/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right 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 > 10

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 7. Currently taking 5 or more medications, 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:Yes

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, swelling in legs/around eyes, M1400 - Dyspnea, M1033 - Unintentional Weight Loss, swelling in the arms/legs, cramping calves/thighs/hips, abn cholesterol > 200 mg/dL, abnormal blood pressure, abnormal thyroid <> 0.40 - 4.50 mIU/mL, muscle weakness, poor muscle tone, swelling of affected area, limited strength, limited range of motion, limited endurance, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, red/tender pressure points, swell/redness surround. skin, open sores/lesions, discolored patches of skin, bruising/discoloration

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care, wound vacuum, glucose testing via monitor, monitor intake & output, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

SN Goals

PATIENT-STATED GOAL: To get back to my normal self

GOALS
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

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/caregiver recalls
* strategies to increase caloric intake
* recalls related medication(s) purpose, schedule

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

patient is adequately supervised

caregiver administers and/or packages medications appropriately

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

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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 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, * strategies to increase caloric intake, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

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, 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, 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 R 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 - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: I want to be able to take walks again

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Car Transfer - 06. Independent

Toileting Hygiene - 06. Independent

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

Don/Doff Footwear - 05. Setup or clean-up assistance

Upper Body Dressing - 06. Independent

Sit to Stand - 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

Eating - 06. Independent

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

Oral Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

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

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