Home Health Certification and Plan of Care

Order ID: 1150/21168

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
89347985	08/07/2026	From: 08/07/2026 To: 10/05/2026	28307	217058

6. Patient's Name and Address

Kathy Alford
1 Brett CT, Apt 221,
ESSEX, MD 21221-
443-761-3401

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 07/24/1955 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	08/07/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	08/07/26
M17.12	Unilateral primary osteoarthritis left knee	08/07/26
J45.20	Mild intermittent asthma uncomplicated	08/07/26
I34.1	Nonrheumatic mitral (valve) prolapse	08/07/26
E04.1	Nontoxic single thyroid nodule	08/07/26
E78.5	Hyperlipidemia unspecified	08/07/26
F32.A	Depression unspecified	08/07/26
F41.9	Anxiety disorder unspecified	08/07/26
R73.03	Prediabetes	08/07/26
E66.9	Obesity unspecified	08/07/26
Z68.33	Body mass index [BMI] 33.0-33.9 adult	08/07/26
Z79.51	Long term (current) use of inhaled steroids	08/07/26
Z79.82	Long term (current) use of aspirin	08/07/26
Z87.891	Personal history of nicotine dependence	08/07/26

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

PROZAC 20 MG / 1 Capsule by mouth daily
LIPITOR 40 MG / 1 Tablet by mouth once a day For cholesterol and heart protection. (5/29/26: Note increase in dose. Go to lab for new baseline lipid panel prior to starting 40 mg dose).
COLACE 100 MG / 1 Capsule by mouth 2 times a day
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, 1 tablet by mouth every 4 hours As Needed for pain
Extra Strength Tylenol - Acetaminophen 500mg, 2 tablets not available every 6 hours
Carbamide Peroxide (EAR WAX REMOVAL DROPS) 6.5 % Otic Drop / Instill 5 Drops into affected ear(s) Otic twice a day
Lidocaine Patch - Lidocaine 4 % Top PTMD Patch / Apply 1 Patch to skin transdermal once a day May keep patch in place for up to 12 hours in a 24-hour period

14. DME and Supplies:

rolling walker, hand held shower, reacher, 4 wheeled walker, walker, grab bars, cane, bath bench

15. Safety Measures:

smoke detectors , emergency phone # clearly displayed, ambulates with assistance, activity supervision, anticoagulant precautions, hand rails, medication safety, supervision at all times, transfer with assist, walker precautions, standard precautions, knee precautions, fall precautions, bleeding precautions, bathroom safety, ambulates with device

16. Nutrition:

cardiac diet,

17. Allergies:

soy!ivp Dye, Beta Adrenergic Blockers Hydromorphone Hydrochloride Nickel Per

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Exercises Prescribed, Up As Tolerated, Cane, Walker

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
family/caregiver 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:

The patient is a 71-year-old female with a past medical history significant for osteoarthritis of the left knee, mild intermittent asthma, nonrheumatic mitral valve prolapse, hyperlipidemia, depression, anxiety, and other chronic conditions. She recently underwent an elective right total knee replacement and returned to the community following same-day surgery. The patient is alert and oriented 4 and has recently transitioned to a senior living facility, where she currently resides alone; her son lives nearby and is available to provide support as needed. Skilled nursing assessment was completed, and vital signs were within normal limits. The patient denied shortness of breath, headache, nausea, or vomiting. She reported severe postoperative pain rated 10/10 at the right surgical site and had just completed a physical therapy session at the time of assessment. The right knee surgical site was covered with an Aquacel dressing, with planned removal on postoperative day 7 per postoperative instructions. Mild bruising was noted surrounding the surgical site. No other acute postoperative concerns were reported during the visit. Skilled nursing provided education regarding the prescribed pain management protocol, medication compliance, medication frequency, and the importance of taking medications as directed. The patient's morning medications were administered, and teaching was provided regarding appropriate administration frequency. Additional postoperative education included the use of ice/cold therapy for pain and edema management, prevention of constipation associated with postoperative medications and decreased mobility, appropriate use of compression socks, proper lower-extremity positioning, and monitoring for signs and symptoms of infection or other postoperative complications. The patient verbalized understanding of the education provided. The patient was also evaluated for skilled home health physical therapy following right total knee replacement. She presents with postoperative pain, decreased right lower-extremity range of motion and strength, impaired balance, ambulatory dysfunction, and deficits in bed mobility and transfers. She is considered a high fall risk and requires assistance with mobility and functional activities. Leaving the residence requires a considerable and taxing effort due to her current postoperative limitations. Without skilled physical therapy intervention, the patient is at increased risk for further functional decline, falls, and loss of independence. Skilled PT interventions were initiated to address strength, range of motion, balance, gait, transfers, functional mobility, and safety. The patient was educated on edema management, proper lower-extremity positioning, and recognition of signs and symptoms of potential infection. A home exercise program was initiated, including ankle pumps, long arc quadriceps exercises, seated heel slides, quadriceps sets, and gluteal sets, with instruction provided for proper technique and performance. The patient was also instructed in the setup and use of the Cryo/Cryocuff cold therapy machine, including preparation of frozen water bottles for use in maintaining the ice supply. Continued skilled nursing and physical therapy services are indicated to monitor postoperative recovery, manage pain and edema, improve strength and mobility, reduce fall risk, promote safe functional independence, and facilitate progression toward the patient's prior level of function.
 Date of Order 08/07/2026 Orders Physician Face-to-Face Date: 07/22/2026 Clinical Condition Requiring Home Care per

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 08/07/2026

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 : 07/22/2026

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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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 (08/07/26-08/08/26) ,WK2: 1 (08/09/26-08/15/26)

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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, dependent edema (CR), M1400 - Dyspnea, muscle weakness (MS), limited endurance (MS), limited range of motion (MS), limited strength (MS), Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, obesity (NU), bruising/discoloration (SK), #1 - Non-Observable Surgical Wound - Anterior Right Knee - , swell/redness surround. skin

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Knee -: Right knee: Remove Aquacel dressing on the right knee surgical site and leave open to air. Otherwise, cover with a dry dressing if drainage occurs., cough/deep breathing exercises, incentive spirometer, teach/coordinate/arrange medication packaging and/or administration

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 measurements, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately

SN Goals

PATIENT-STATED GOAL: To walk without pain

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
* 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/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

caregiver administers and/or packages medications appropriately

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

08/07/2026

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PT WK1: 1 (08/07/26-08/08/26) ,WK2: 3 (08/09/26-08/15/26) ,WK3: 2 (08/16/26-08/22/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, 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, 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, GG0170G1 - Car Transfer, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand

PROCEDURES: Medication management : Review medication with pt, cough/deep breathing exercises, incentive spirometer, home exercise program: Supine, qs, Heelslides, aps, slr, seated hip flexion, laq, seated heelslodes 20 second holds approx 5-10 of them, heelraises, knee extension stretch 20 second holds x5-10 reps, standing tkes on rle, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car 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, Picking Up Object - 05. Setup or clean-up 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, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PATIENT-STATED GOAL: To be independent walker better and return to work

GOALS
Chair to Bed to Chair - 06. Independent

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
* 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

Sit to Stand - 06. Independent

Car 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

4 Steps - 05. Setup or clean-up assistance

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

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Eating - 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	08/07/2026