Home Health Certification and Plan of Care

Order ID: 1150/21614

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
94246470	08/26/2026	From: 08/26/2026 To: 10/24/2026	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** Female

11. ICD	Principal Diagnosis	Date
M17.11	Unilateral primary osteoarthritis right knee	08/26/26

13. ICD	Other Pertinent Diagnoses	Date
K22.70	Barrett's esophagus without dysplasia	08/26/26
E78.5	Hyperlipidemia unspecified	08/26/26
K21.9	Gastro-esophageal reflux disease without esophagitis	08/26/26
M81.0	Age-related osteoporosis w/o current pathological fracture	08/26/26
E87.1	Hypo-osmolality and hyponatremia	08/26/26
D80.2	Selective deficiency of immunoglobulin A [IgA]	08/26/26
M48.061	Spinal stenosis lumbar region without neurogenic claud	08/26/26
G57.30	Lesion of lateral popliteal nerve unspecified lower limb	08/26/26
I70.0	Atherosclerosis of aorta	08/26/26
N32.81	Overactive bladder	08/26/26
K59.00	Constipation unspecified	08/26/26
K44.9	Diaphragmatic hernia without obstruction or gangrene	08/26/26
D69.2	Other nonthrombocytopenic purpura	08/26/26
F41.9	Anxiety disorder unspecified	08/26/26
H04.123	Dry eye syndrome of bilateral lacrimal glands	08/26/26
R73.03	Prediabetes	08/26/26
Z85.820	Personal history of malignant melanoma of skin	08/26/26
Z86.0100	Personal history of colonic polyps	08/26/26
Z86.16	Personal history of COVID-19	08/26/26
Z96.652	Presence of left artificial knee joint	08/26/26

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
Tramadol - Tramadol Hydrochloride 50 Mg, Take 1 tablet by mouth every 4 hours For pain

14. DME and Supplies:

grab bars, cane, rolling walker

15. Safety Measures:

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

16. Nutrition:

regular

17. Allergies:

doxycycline amoxicillin with clavulanate potassium cipro metronidazole

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

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: 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

family/caregiver will be responsible for managing treatment

Homebound status: After undergoing Total right 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 with a past medical history significant for bilateral knee osteoarthritis who is admitted to home health for postoperative care requiring ongoing skilled monitoring and management following a right total knee replacement (TKR). Upon arrival, the patient was resting comfortably in a recliner with her husband present. She was alert and oriented x3 and denied chest pain or other acute discomfort. The patient reported significant postoperative pain rated 8/10 at the right surgical site but stated that her prescribed pain medication is effective when taken as directed. The non-removable surgical dressing was dry and intact, with removal planned approximately seven days postoperatively. The patient reported her last bowel movement was yesterday without complications. Mild edema was noted in the right lower extremity, and TED stockings were in place as prescribed. The patient is scheduled for a postoperative follow-up appointment with the surgeon on 8/28/2026. Medication review was completed, with no missing medications or refill needs identified. Admission paperwork was completed and signed, and the patient verbalized agreement with the plan of care. Continued skilled nursing services are indicated for postoperative assessment, monitoring of the surgical site, pain and edema management, medication monitoring, and prevention of postoperative complications. Physical therapy interventions focused on improving right knee mobility and managing postoperative pain and edema. Patellar mobilization and massage techniques, including fluid-flush massage to the knee, were performed, followed by active-assisted range-of-motion exercises for knee flexion and extension. An ice pack was applied for approximately 12-25 minutes, followed by a recommended rest period of approximately one hour. The patient's pain is currently impacting functional performance, mobility, and participation in therapeutic activities. She reports that, compared with her previous left TKR performed in May 2026, the right knee feels significantly more tender and is more difficult to move and ambulate with. The patient presents with anxiety related to the severity of her postoperative pain and reports that the pain is occupying much of her attention and affecting her perception of the healing process. Education and reassurance were provided regarding postoperative pain management, safe progression of activity, use of prescribed pain medication, positioning, edema control,

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 08/26/2026

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 : 08/13/2026

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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and appropriate use of ice therapy. The patient will continue with skilled therapy to address pain, range of motion, strength, gait, functional mobility, and safety while monitoring her response to treatment and progression toward functional recovery.
 Date of Order 08/26/2026 Orders Physician Face-to-Face Date: 08/13/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Total right 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 (08/26/26-08/29/26) ,WK2: 1 (08/30/26-09/05/26)

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; 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

08/31/2026 Problems : #1 - Non-Observable Surgical Wound - Other - Right Total Knee Replacement - Right TKR
balance deficit (NR)
muscle weakness (MS)
frequent urination (GU)
constipation (GI)
Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
swelling of affected area
limited endurance
limited strength
limited range of motion
meal preparation
M2102d - Caregiver Performs Treatment
M2102f - Patient Supervision
M1610 - Urinary Incontinence

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Right Total Knee Replacement - Right TKR: Assess the patient's incision on post op day 7 and the nurse or

SN Goals

PATIENT-STATED GOAL: To be able to get around and do everything I was and get this pain under control

GOALS
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 achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

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

meal preparation is available to patient for all meals

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/26/2026

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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., cough/deep breathing exercises, incentive spirometer

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, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 3 (08/26/26-08/29/26) ,WK2: 3 (08/30/26-09/05/26)

08/26/2026 Problems : GG0170M1 - 1 - Step (curb)
GG0130A1 - Eating
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130F1 - Upper 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
Pain Effect on Sleep
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
M1400 - Dyspnea
Pain Interference with ADLs
Pain Interference with Therapy activities

PROCEDURES: cough/deep breathing exercises: 10 cycles / hour while awake, incentive spirometer: 10 cycles / hour while awake , exhale all air , seal lips , inhale SLOWLY , keep disc in center, home exercise program: ankle pumps 1/10 . windshield wiper movement , alphabet, heel slides , Quad sets 1/20 each , sit stand 1/3 , gait with walker 3 times perimeter of interior , twice daily , cold post stretches, massage fluid flush, equipment training: inspirometer, walker train indoors , adjust height , describe and instruct braking, work simplification/energy conservation: placing items within reach to avoid unnecessary trips , while healing, gait training on uneven surfaces: step downs introduced , walker placement at edge with brake control, gait training/stair training: begin with graded step , 1/2 height standard rise for now , add step full rise as soon as capable., transfers training: nose over toes , head down until standing fully , reverse mechanics when sitting , calves touching the seating surface.

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

PT Goals

PATIENT-STATED GOAL: Patient wants to be able to return to dancing with her spouse, attend social events

GOALS
Toilet Transfer - 06. Independent

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

Chair to Bed to Chair - 06. Independent

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

Car Transfer - 06. Independent

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

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

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

Walk 10 Feet - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Eating - 06. Independent

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

Toileting Hygiene - 06. Independent

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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