Home Health Certification and Plan of Care

Order ID: 1150/15765

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
87335955	01/21/2026	From: 01/21/2026 To: 03/21/2026	21019	217058

6. Patient's Name and Address

George Frazier
424 S Dallas St,
BALTIMORE, MD 21231-
410-925-6162

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 04/21/1947 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	01/21/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	01/21/26
M51.360	Other intvrt disc degen	01/21/26
K21.9	Gastro-esophageal reflux disease without esophagitis	01/21/26
I71.9	Aortic aneurysm of unspecified site without rupture	01/21/26
H25.13	Age-related nuclear cataract bilateral	01/21/26
M23.321	Oth meniscus derang post horn of medial meniscus r knee	01/21/26
R91.1	Solitary pulmonary nodule	01/21/26
H91.93	Unspecified hearing loss bilateral	01/21/26
Z79.82	Long term (current) use of aspirin	01/21/26
Z79.52	Long term (current) use of systemic steroids	01/21/26
Z87.891	Personal history of nicotine dependence	01/21/26
Z96.643	Presence of artificial hip joint bilateral	01/21/26
Z97.4	Presence of external hearing-aid	01/21/26

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

Proventil-Hfa - Albuterol Sulfate 90 mcg/actuation Inhl HFAA, Inhale 2 Puffs inhalant every 6 hours Inhale 2 Puffs by mouth every 6 hours as needed (rescue inhaler)
Colace - Docusate Sodium 100 mg, Take 1 capsule (100 mg total) by mouth twice a day Take 1 capsule (100 mg total) by mouth 2 (two) times daily for 20 days.
8-Hour Bayer - Aspirin 81 mg TWO TIMES A DAY
0 - Acetaminophen: Oxycodone Hydrochloride 5-10 mg Oral EVERY 4-6 HOURS AS NEEDED
Extra Strength Tylenol - Acetaminophen 500mg (2) by mouth every 6 hours inflammation

14. DME and Supplies:

commode, walker

15. Safety Measures:

knee precautions, bathroom safety, supervision at all times, , walker precautions, , ambulates with assistance, ambulates with device

16. Nutrition:

regular

17. Allergies:

patnoprazole sodium

18.A. Functional Limitations

Ambulation, Endurance

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 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 an adult male status post right total knee replacement performed on 01/20/2026, currently admitted to home health services due to impaired mobility and increased fall risk, making it a taxing effort to leave the home. The patient is considered homebound as evidenced by the significant effort required to ambulate safely and a Tinetti balance and gait score of 11/28. The orthopedic surgeon is Dr. Huang, with a postoperative follow-up appointment scheduled for 02/02/2026. The patient's past medical and surgical history is significant for bilateral hip replacements, prior spinal surgery, and osteoarthritis. On start-of-care assessment, the patient was alert and oriented to person, place, time, and situation. He reported right knee pain rated at 5/10, which is being managed with prescribed pain medications and anti-inflammatory agents. Education was provided regarding pain management strategies, including proper medication use and the application of ice therapy as directed. The patient denied dizziness, lightheadedness, chest pain, shortness of breath, nausea, vomiting, urinary discomfort, or recent falls. Appetite was reported as fair, and the patient stated his last bowel movement occurred on the day of assessment. Lungs were clear to auscultation bilaterally. Incentive spirometer use was reviewed and reinforced to promote pulmonary hygiene. The patient ambulates indoors using a rolling walker for safety and fall prevention, achieving approximately 30 feet with supervision and verbal cues for improved gait pattern. He is able to negotiate 14 stairs using a handrail with supervision. Transfers to bed and chair, as well as bed mobility, are performed with supervision. Right knee range of motion was measured at 10-80 degrees. Outside ambulation and car transfers were not assessed at this time. The patient resides alone in a townhouse with bedroom and bathroom located on the second floor. He reports having friends and family available for assistance as needed, and his emergency contact is his sister, Lynn, who resides out of state. Surgical incision dressing was assessed and found to be clean, dry, and intact, with no signs of abnormal bleeding, increased bruising, swelling, or infection. The patient was instructed not to get the dressing wet or soak the incision site. No additional wounds were noted on assessment. Education was provided regarding signs and symptoms of infection or complications, and the patient was instructed to contact the surgeon immediately if increased pain, swelling, bruising, redness, drainage, or bleeding occurs. The patient was also instructed on maintaining adequate hydration to prevent dehydration. Medications were reviewed in detail, including purpose, dosing, and potential side effects, and the patient demonstrated understanding. The plan of care includes continued skilled

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 01/21/2026

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 : 12/31/2025

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.

Home Health Certification and Plan of Care

Order ID: 1150/15765

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
87335955	01/21/2026	From: 01/21/2026 To: 03/21/2026	21019	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
George Frazier 424 S Dallas St, BALTIMORE, MD 21231- 410-925-6162	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

nursing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> for postoperative monitoring, incision assessment, dressing removal, measurement, and photographic documentation at the next visit, as well as ongoing education. Skilled physical therapy services are recommended to address deficits in strength, range of motion, gait, balance, stair negotiation, and functional mobility with the goal of improving safety, reducing fall risk, and promoting a return to prior level of independence within the home environment.
 Date of Order 01/21/2026 Orders Physician Face-to-Face Date: 12/31/2025 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: PT Eval Notes: eval
 Physician Huang , James

SN Careplans

SN WK1: 1 (01/21/26-01/24/26) ,WK2: 1 (01/25/26-01/31/26)

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: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 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; 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.

s/p right knee joint replacement dressing remove 7-day post-surgery dressing removed measure incision and photograph
Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1400 - Dyspnea, limited range of motion, limited endurance, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Knee -

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Knee -, cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: s/p right knee joint replacement dressing to remain intact, remove 7-day post-surgery dressing removed measure incision and photograph, home exercise program, coordinate/arrange preparation of missing meals, 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 medicatio, * 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 relaxatio, * 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 optimize joint mobility with active and passive range of

SN Goals

PATIENT-STATED GOAL: resume normal activity

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 optimize joint mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* pain control
* recalls related medication(s)

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 medicatio

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 relaxatio

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

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	01/21/2026

Home Health Certification and Plan of Care

Order ID: 1150/15765

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
87335955	01/21/2026	From: 01/21/2026 To: 03/21/2026	21019	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
George Frazier 424 S Dallas St, BALTIMORE, MD 21231- 410-925-6162	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

motion exercises fluid and diet intake to promote healing prevent constipation home safety pain control, related medication(s) , * how to keep home safe for hearing-impaired including installing special fire-detector/C O2 alarms, 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: 2 (01/21/26-01/24/26) ,WK2: 3 (01/25/26-01/31/26) ,WK3: 1 (02/01/26-02/07/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, 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, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130B1 - Oral Hygiene, #2 - Observable Surgical Wound - Anterior Right Knee -

PROCEDURES: physician-ordered wound care: #2 - Observable Surgical Wound - Anterior Right Knee -, Home exercise program : Supine 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 , physician-ordered wound care, wound vacuum, equipment training, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * 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 relaxatio, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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, Lower Body Dressing - 03. Partial/moderate assistance, Don/Doff Footwear - 03. Partial/moderate assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: Walk independently without pain using a cane

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

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

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Car Transfer - 06. Independent

Walk 150 Feet - 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 - 03. Partial/moderate assistance

Don/Doff Footwear - 03. Partial/moderate 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 relaxatio

Sit to Stand - 06. Independent

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

Oral Hygiene - 06. Independent

Eating - 06. Independent

12 Steps - 05. Setup or clean-up assistance

Toileting Hygiene - 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	01/21/2026