

Home Health Certification and Plan of Care				Order ID: 1150/16549	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
01121811		02/25/2026		From: 02/25/2026 To: 04/25/2026	
				4. Medical Record No.	
				2467	
				5. Provider No.	
				217058	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Crystal Gardner 1913 Quentin Road, Dundalk, MD 21222- 443-788-2739				HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239	
8. DOB 11/16/1962 9.Sex Female				10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
11. ICD		Principal Diagnosis		Tylenol - Acetaminophen 500 MG by mouth every 4 hours 1 TAB, PRN	
T84.032D		Mech loosening of internal right knee prosthetic joint subs		Asa 81 Mg - Aspirin 81mg; 1 tab by mouth twice a day post op left tkr	
				Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, 1 tablet by mouth every 4 hours As needed for pain	
13. ICD		Other Pertinent Diagnoses		Ibuprofen - Ibuprofen 600 mg Take 1 tablet by mouth every 8 hours As needed for pain	
I11.0		Hypertensive heart disease with heart failure		Colace - Docusate Sodium 100 mg, Take 1 capsule by mouth twice a day	
I50.30		Unspecified diastolic (congestive) heart failure		Stool softener	
G47.33		Obstructive sleep apnea (adult) (pediatric)		Furosemide - Furosemide 20 mg Take 1 tablet by mouth at bedtime Diuretics	
I34.0		Nonrheumatic mitral (valve) insufficiency		Vitamin D - Ergocalciferol 50,000 International Units Take 1 tablet by mouth once a week Supplement	
I83.93		Asymptomatic varicose veins of bilateral lower extremities			
B00.89		Other herpesviral infection			
K44.9		Diaphragmatic hernia without obstruction or gangrene			
E66.9		Obesity unspecified			
Z68.35		Body mass index [BMI] 35.0-35.9 adult			
Z79.82		Long term (current) use of aspirin			
Z96.652		Presence of left artificial knee joint			
Z90.3		Acquired absence of stomach [part of]			
Z87.891		Personal history of nicotine dependence			
14. DME and Supplies:				15. Safety Measures:	
bath bench, walker				ambulates with device, walker precautions, , activity supervision, bathroom safety,	
16. Nutrition:				17. Allergies:	
regular				aspirin chlorhexidine gluconate ibuprofen	
18.A. Functional Limitations				18.B. Activities Permitted	
Ambulation				Up As Tolerated	
19. Mental & COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Pyschosocial Status: Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No					
20. Prognosis: fair					
22. A Rehabilitation Potential:				22.B.Discharge Plans	
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.				patient will be responsible for managing treatment another facility/provider will be responsible for managing treatment	
Homebound status: Due to diagnosis of Mechanical Loosening Of Internal Right Knee Prosthetic Joint, Subsequent Encounter, 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:<div>The patient is a 63-year-old female with a past medical history significant for genital herpes simplex, osteoarthritis, hialal hernia, heart failure, hypertension, and other chronic comorbidities. She is status post right total knee replacement revision surgery. This procedure was performed as a revision of a prior right total knee arthroplasty completed last year, which subsequently failed. The patient temporarily relocated from North Carolina to recover at her son's residence following surgery. All prescribed medications are present in the home and available for administration as ordered. On assessment, the patient was alert and oriented to person, place, time, and situation. Vital signs were within normal limits at the time of evaluation. She reports severe postoperative pain and presents with notable right lower extremity edema and an unsteady gait. She ambulates with a rolling walker and requires instruction and supervision for safety due to pain, weakness, and impaired balance. Postoperative swelling is present, consistent with recent surgical intervention. During the visit, the patient was positioned safely in a recliner and participated in therapeutic exercises to promote range of motion, strength, and circulation. Supine and seated exercises included heel slides and lower extremity abduction/adduction, as well as long arc quadriceps exercises. In standing, she performed marching and heel raises with assistance and cueing to ensure proper technique and safety. She was educated and trained in the safe use of her rolling walker to reduce fall risk and improve gait stability. Instruction was also provided on appropriate use of cryotherapy for pain and edema management. Comprehensive education was delivered regarding pain management strategies, including adherence to prescribed analgesics, use of ice therapy, limb elevation, and consistent use of compression stockings to manage postoperative swelling. Additional teaching included medication compliance, personal and hand hygiene to reduce infection risk, and reinforcement of postoperative precautions. The patient demonstrated understanding of the education provided. The plan of care includes continued skilled therapy services to address pain control, reduce edema, improve lower extremity strength and range of motion, and enhance gait stability and overall functional mobility. Ongoing monitoring of cardiovascular status is warranted given her history of heart failure and hypertension. The goal is to promote safe recovery from revision total knee replacement, restore functional independence, and prevent postoperative complications.</div><div> </div><div>Date of Order</div><div>02/25/2026</div><div>Orders</div><div>Physician Face-to-Face Date: 02/11/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Mechanical Loosening Of Internal Right Knee Prosthetic Joint, Subsequent Encounter</div><div>Homebound Status per Certifying Physician: patient requires another</div></div>					
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 02/25/2026					
24. Physician's Name and Address				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.	
James Huang 8028 Ritchie Hwy Pasadena, MD 21122 PHONE: 410-737-5600 FAX: 14107375391 NPI: 1154567709				F2F date : 02/11/2026	
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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person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div>
</div><div>1 - SOC - SN Notes: soc</div><div>PT Eval Notes: eval</div><div>
</div><div>Huang , James</div></div>

SN Careplans

SN WK1: 1 (02/25/26-02/28/26) ,WK2: 1 (03/01/26-03/07/26)

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, 8. Currently reports exhaustion, 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:Durable power of attorney for health care/Medical power of attorney

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Right Knee - Right knee replacement surgery

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Knee - Right knee replacement surgery: Remove the Mepilex dressing 7 days post op and LOTA, cover with a dry gauze if drainage occurs., 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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

SN Goals

PATIENT-STATED GOAL: To be able to recover fully

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/caregiver recalls

- * strategies to minimize fatigue and exhaustion including work simplification
- * energy conservation
- * lifestyle changes
- * diet
- * recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed

- * recalls related medication(s) purpose, schedule

PT Careplans

PT Goals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/25/2026

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PT WK1: 2 (02/25/26-02/28/26) ,WK2: 3 (03/01/26-03/07/26) ,WK3: 1 (03/08/26-03/14/26) PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0170G1 - Car Transfer, 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, GG0130B1 - Oral Hygiene, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing PROCEDURES: cough/deep breathing exercises, incentive spirometer, equipment training, 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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 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 - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent			PATIENT-STATED GOAL: To walk pain free 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 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 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 - 06. Independent Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Upper Body Dressing - 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	

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