Home Health Certification and Plan of Care

Order ID: 1150/17745

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
32214479	04/02/2026	From: 04/02/2026 To: 05/31/2026	23583	217058

6. Patient's Name and Address

Lewis Chester
1 W Conway St Apt 816,
BALTIMORE, MD 21201-
443-488-2969

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 01/22/1951 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	04/02/26

13. ICD	Other Pertinent Diagnoses	Date
E78.5	Hyperlipidemia unspecified	04/02/26
M19.041	Primary osteoarthritis right hand	04/02/26
M19.042	Primary osteoarthritis left hand	04/02/26
M54.32	Sciatica left side	04/02/26
G56.02	Carpal tunnel syndrome left upper limb	04/02/26
G56.22	Lesion of ulnar nerve left upper limb	04/02/26
K63.5	Polyp of colon	04/02/26
H40.10X0	Unspecified open-angle glaucoma stage unspecified	04/02/26
H40.32X0	Glaucoma secondary to eye trauma left eye stage unsp	04/02/26
Z96.652	Presence of left artificial knee joint	04/02/26
Z79.82	Long term (current) use of aspirin	04/02/26

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

Ecotrin - Aspirin Delayed Release 81 mg / 1 Tablet by mouth twice a day Patient not taking; Reported on 3/25/2026)
COLACE 100 mg / 1 Capsule by mouth twice a day Patient not taking; Reported on 3/25/2026)
Zofran Odt - Ondansetron 4 mg / 1 Tablet by mouth every 8 hours as needed Dissolve 1 tablet on the tongue for nausea or vomiting. Patient not taking; Reported on 3/25/2026)
ROXICODONE 5 mg/tablet / Take 1 to 2 tablets by mouth every 4 hours as needed for pain.
LIPITOR 40 mg / 1 Tablet by mouth daily for cholesterol
TOPROL-XL SR 50 mg / 1 Tablet Oral daily
XALATAN 0.005 % Opht Drop / Instill 1 Drop both eyes daily at bedtime
COSOPT 22.3 6.8 mg/mL Opht Drop / Instill 1 Drop left eye once a day
VOLTAREN ARTHRITIS PAIN 1 % Top Gel / Apply 2 g to affected area(s) topical 4 times a day (OTC Product)
CARMOL 20 20 % Top Cream / Apply to affected area(s) topical twice a day (Patient not taking: Reported on 3/25/2026)

14. DME and Supplies:

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

15. Safety Measures:

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

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: NA Patient nonresponsive, 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: 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 Left 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 67-year-old male status post left total knee replacement performed on 04/01, currently recovering at home and resting comfortably. He reports minimal pain and swelling at this time. The patient resides alone in an apartment with intermittent assistance from his son and is ambulating with the use of a walker. He is a full code with no known drug allergies (NKDA), and a MOLST form is on file. All prescribed medications are present in the home. Assessment of the surgical site reveals the dressing to be clean, dry, and intact with no signs or symptoms of infection. The patient is scheduled to begin outpatient physical therapy within the next few weeks to support continued recovery and functional improvement. Additionally, the patient has a history significant for osteoarthritis, status post knee replacement (2021), <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-hypertension">hypertension</mh>, and <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-10 CE-FMS-hyperlipidemia">hyperlipidemia</mh>. Functionally, he is able to ambulate approximately 30 feet on indoor surfaces using a rolling walker with a step-to gait pattern under supervision. Bed mobility is independent, and he demonstrates independence with sit-to-stand transfers from the bed, chair, and toilet. Assessment of stair negotiation, outdoor mobility, and car transfers was not completed during this visit. The patient is considered homebound due to the considerable effort required to leave the home with an assistive device, further supported by a Tinetti balance and gait score of 13/28, indicating an increased fall risk. He resides in an elevator-accessible apartment with no steps required for entry or exit. During the visit, the patient participated in therapeutic exercises and tolerated 10 repetitions each of quadriceps sets, short arc quadriceps exercises, hip flexion, hip abduction, knee extension, and ankle pumps. Left knee range of motion was measured at 0 to 95 degrees. The patient would benefit from continued skilled home physical therapy services to improve strength, range of motion, balance, and overall functional mobility with the goal of returning to his prior level of independence. Education was provided regarding safe ambulation with an assistive device, fall prevention strategies, and adherence to the prescribed home exercise program. The plan of care includes progression of therapeutic exercises, gait training, and functional mobility training, with transition to outpatient therapy as clinically appropriate.
 Date of Order 04/02/2026 Orders Physician Face-to-Face Date: 03/25/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left 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 Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/02/2026

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 : 03/25/2026

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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SN WK1: 1 (04/02/26-04/04/26) ,WK2: 1 (04/05/26-04/11/26)

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:MOLST

PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M2020 - Oral Med Management, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, dependent edema, muscle weakness, limited range of motion, swelling of affected area, limited strength, limited endurance, balance deficit, bruising/discoloration, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Other - Left Knee - Left TKA surgical wound

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Left Knee - Left TKA surgical wound: 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., 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 keep home safe for patient with dementia coping strategies for the caregiver*, 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

PATIENT-STATED GOAL: Patient states he wants to be able to walk up and down stairs again without any 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
* 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 keep home safe for patient with dementia
* coping strategies for the caregiver* 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 WK1: 2 (04/02/26-04/04/26) ,WK2: 3 (04/05/26-04/11/26) ,WK3: 1 (04/12/26-04/18/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170P1 - Picking Up Object, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, GG0170F1 - Toilet Transfer, 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

PT Goals

PATIENT-STATED GOAL: To be able to walk independently with cane and exit the building

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

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

Toilet Transfer - 06. Independent

Walk 150 Feet - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/02/2026

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PROCEDURES: Home exercise program : Supine hip flexion, quad sets, short arc quads, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, 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 relaxation skills and diversional activities, related medication(s) purpose, schedule, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet 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, Picking Up Object - 05. Setup or clean-up assistance, Car Transfer - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 05. Setup or clean-up assistance, Upper Body Dressing - 06. Independent

Car Transfer - 05. Setup or clean-up assistance

Don/Doff Footwear - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

Eating - 05. Setup or clean-up assistance

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

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

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

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

Lower Body Dressing - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
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