

Home Health Certification and Plan of Care				Order ID: 1150/18053	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
38298835		04/18/2026		From: 04/18/2026 To: 06/16/2026	
				4. Medical Record No.	
				24299	
				5. Provider No.	
				217058	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Georgia Holmes				HomeCentris Healthcare LLC	
104 Pleasant Ridge Dr Apt 226,				10 Crossroads Drive, Suite 102	
OWINGS MILLS, MD 21117-				Owings Mills, MD 21117-8284	
443-450-6184				410-321-8448	
				1487113239	
8. DOB 07/26/1943 9.Sex Female				10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
11. ICD Z47.1		Principal Diagnosis Aftercare following joint replacement surgery		Date 04/18/26	
13. ICD Z96.652 I10. J45.20 I70.0 M81.0 R73.03 R32. Z79.82		Other Pertinent Diagnoses Presence of left artificial knee joint Essential (primary) hypertension Mild intermittent asthma uncomplicated Atherosclerosis of aorta Age-related osteoporosis w/o current pathological fracture Prediabetes Unspecified urinary incontinence Long term (current) use of aspirin		Date 04/18/26 04/18/26 04/18/26 04/18/26 04/18/26 04/18/26 04/18/26 04/18/26	
14. DME and Supplies: cane, walker,				15. Safety Measures: knee precautions, ambulates with device, walker precautions, medication safety, standard precautions, bleeding precautions, fall precautions, anticoagulant precautions	
16. Nutrition: cardiac diet,				17. Allergies: latex lisinopril	
18.A. Functional Limitations Ambulation, Endurance				18.B. Activities Permitted Cane, Walker, Exercises Prescribed	
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: 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	
Homebound status: After undergoing Left Total Knee Replacement surgery, 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: <p class="MsoNoSpacing">The patient is an 82-year-old female status post left total knee replacement (04/16/2026), with a past medical history significant for hypertension, intermittent asthma, osteoporosis, prediabetes, atherosclerosis of the aorta, and prior right total knee arthroplasty, currently referred for skilled home health services. She lives alone with family assistance available as needed and is alert and oriented 3. She reports pain at 5/10, having taken pain medication prior to the visit, denies shortness of breath, has a fair appetite, and reports no bowel movement since prior to surgery, with nausea noted during the visit (likely anesthesia-related). The left knee surgical incision is covered with an intact, clean, and dry Aquacel dressing, and she is wearing TED stockings. Functionally, the patient presents with left lower extremity weakness, decreased knee range of motion, impaired balance with increased fall risk, and an antalgic gait; she requires moderate assistance for transfers and to ambulate 25-30 feet with a rolling walker, while bed mobility is at modified independence. She is homebound due to the need for an assistive device and assistance for safe mobility. Medications, postoperative instructions, pain management, and nausea education were reviewed, and the patient was receptive. Skilled nursing is planned once weekly for two weeks, and skilled physical therapy is indicated to address deficits in strength, range of motion, gait, and balance and to promote safe, independent function.</p></o:p></p> <p class="MsoNoSpacing"><o:p> </o:p></p> <p class="MsoNoSpacing">Date of Order<o:p></o:p></p> <p class="MsoNoSpacing">04/18/2026 Physician Face-to-Face Date: 03/31/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left Total Knee Replacement surgery Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p></p> <p class="MsoNoSpacing"> 1 - SOC - SN Notes: PT Eval Notes: <o:p></o:p></p><p class="MsoNoSpacing">Physician: Huang, James</p>					
SN Careplans				SN Goals	
SN WK1: 1 (04/18/26-04/18/26) ,WK2: 1 (04/19/26-04/25/26)				PATIENT-STATED GOAL: I WANT TO FEEL BETTER	
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				GOALS patient/caregiver recalls	
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance				* how to achieve wound healing including cleaning and dressing wound	
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8				* position changes	
STANDING ORDERS: hygiene 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				* 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	
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Messick, Charles RN on 04/18/2026				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 : 03/31/2026	
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.	
				PAGE 1 of 3	

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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. LEFT KNEE Advance Directive:No Advance Directive PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited range of motion, swelling of affected area, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Left Knee - DRESSING INTACT NO DRAINAGE NOTED PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee - DRESSING INTACT NO DRAINAGE NOTED, physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee - DRESSING INTACTNO DRAINAGE NOTED: SN TO REMOVE LEFT KNEE DRESSING POST OP DAY 7, cough/deep breathing exercises, incentive spirometer, home exercise program 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, meal preparation is available to patient for all meals				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 * 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 meal preparation is available to patient for all meals		
PT Careplans PT WK2: 2 (04/19/26-04/25/26) ,WK3: 3 (04/26/26-05/02/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170I1 - Walk 10 Feet, 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, GG0130B1 - Oral Hygiene, GG0170G1 - Car Transfer, 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: B LE strengthening: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., 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 - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06.				PT Goals PATIENT-STATED GOAL: To have a successful post surgical outcome GOALS Chair to Bed to Chair - 06. Independent Toilet Transfer - 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 Sit to Stand - 06. Independent Car Transfer - 06. Independent Walk 10 Feet - 06. Independent Walk 50 ft with 2 Turns - 06. Independent Walk 150 Feet - 06. Independent Walk 10 ft on Uneven Surface - 06. Independent 1 - Step (curb) - 06. Independent		
Signature of Physician:				Date PAGE 2 of 3		
Optional Name/Signature of Nurse/Therapist: Electronically Signed by Messick, Charles RN				Date 04/18/2026		

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Independent, Picking Up Object - 06. Independent, 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		4 Steps - 06. Independent 12 Steps - 06. Independent Picking Up Object - 06. Independent 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		

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