

Home Health Certification and Plan of Care				Order ID: 1150/21202	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
12212703		08/07/2026		From: 08/07/2026 To: 10/05/2026	
				4. Medical Record No.	
				28305	
				5. Provider No.	
				217058	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Fouzia Qureshi				HomeCentris Healthcare LLC	
5415 King Ave,				10 Crossroads Drive, Suite 102	
ROSEDALE, MD 21237-				Owings Mills, MD 21117-8284	
410-608-2136				410-321-8448	
				1487113239	
8. DOB				9. Sex	
10/10/1968				Female	
11. ICD		Principal Diagnosis		Date	
Z47.1		Aftercare following joint replacement surgery		08/07/26	
13. ICD		Other Pertinent Diagnoses		Date	
Z96.652		Presence of left artificial knee joint		08/07/26	
M17.11		Unilateral primary osteoarthritis right knee		08/07/26	
E11.69		Type 2 diabetes mellitus with other specified complication		08/07/26	
E78.5		Hyperlipidemia unspecified		08/07/26	
E03.9		Hypothyroidism unspecified		08/07/26	
H04.123		Dry eye syndrome of bilateral lacrimal glands		08/07/26	
H52.203		Unspecified astigmatism bilateral		08/07/26	
M19.90		Unspecified osteoarthritis unspecified site		08/07/26	
K21.9		Gastro-esophageal reflux disease without esophagitis		08/07/26	
E66.01		Morbid (severe) obesity due to excess calories		08/07/26	
Z68.36		Body mass index [BMI] 36.0-36.9 adult		08/07/26	
Z79.84		Long term (current) use of oral hypoglycemic drugs		08/07/26	
14. DME and Supplies:				10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
rolling walker, hand held shower, grab bars, walker, diabetic supplies, cane, bath bench				MOBIC 15 MG / 1 Tablet by mouth daily	
				ECOTRIN 0 LOW STRENGTH DR 81 MG / 1 Tablet by mouth 2 times a day	
				COLACE 100 MG / 1 Capsule by mouth 2 times a day	
				Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, 1 tablet by mouth every 4 hours As needed for pain	
				Synthroid - Levothyroxine Sodium 75 MCG / 1 Tablet by mouth every morning 30 minutes before a meal	
				Lipitor - Atorvastatin Calcium 20 MG / 1 Tablet by mouth once a day for cholesterol and heart protection	
				Extra Strength Tylenol - Acetaminophen 500mg, 2 tablets by mouth every 6 hours As needed for pain	
				tirzepatide (MOUNJARO) 2.5 mg/0.5 mL SubQ Pen Injector 0 Inject 2.5 mg subcutaneous once a week (Patient not taking: Reported on 7/8/2026)	
15. Safety Measures:					
bleeding precautions, anticoagulant precautions, walker precautions, standard precautions, medication safety, knee precautions, fall precautions, diabetic precautions, bathroom safety, ambulates with device					
16. Nutrition:				17. Allergies:	
diabetic				no known allergies	
18.A. Functional Limitations				18.B. Activities Permitted	
Endurance, Ambulation				Exercises Prescribed, 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: 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.				SN:family/caregiver will be responsible for managing treatment	
				PT: patient 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 57-year-old female with a past medical history of osteoarthritis of the right knee, hyperlipidemia, hypothyroidism, GERD, and type 2 diabetes mellitus. She is alert and oriented x4 and is status post elective left total knee replacement. The patient returned home the same day with family assistance and currently resides with her son and his family, with her daughter-in-law serving as the primary caregiver. The surgical site is covered with an Aquacel dressing, which is scheduled for removal on postoperative day 7, after which the site will be left open to air. Lungs are clear to auscultation bilaterally. Medication review was completed with the patient. She ambulates with a walker and presents with postoperative pain, decreased ROM and strength, ambulatory dysfunction, impaired balance, and bed mobility and transfer deficits. She is considered a high fall risk, requires assistance with mobility, and reports a taxing effort to leave the home, placing her at risk for further functional decline and loss of independence without continued skilled therapy. Skilled education was provided regarding infection prevention, medication compliance, edema management, proper lower-extremity positioning, ice therapy, constipation prevention, and personal hygiene. The patient was instructed on signs and symptoms of potential infection and verbalized understanding. A home exercise program was initiated, including ankle pumps, seated heel slides, quad sets, LAQ, and gluteal sets. Continued skilled nursing and physical therapy services are indicated for postoperative monitoring, pain and edema management, surgical-site assessment, fall-risk reduction, strengthening, ROM improvement, gait and mobility training, transfer training, and progression of the home exercise program to promote safe recovery and maximize functional independence. Date of Order 08/07/2026 Orders Physician Face-to-Face Date: 07/22/2026 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	
SN WK1: 1 (08/07/26-08/08/26) ,WK2: 1 (08/09/26-08/15/26)				PATIENT-STATED GOAL: To walk without pain	
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	
CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance				patient/caregiver recalls	
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8				* how to achieve wound healing including cleaning and dressing wound	
STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if				* position changes	
				* skin care	
				* diet modification	
				* record wound measurements	
				* recalls related medication(s) purpose, schedule	
				patient/caregiver recalls	
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by Messick, Charles RN on 08/07/2026					
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				F2F date : 07/22/2026	
8028 Ritchie Hwy					
Pasadena, MD 21122					
PHONE: 410-737-5600 FAX: 14107375391 NPI: 1154567709					
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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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: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, abn cholesterol > 200 mg/dL, abnormal BS < 70/140 > mg/dL, abnormal thyroid <> 0.40 - 4.50 mIU/mL, limited range of motion, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, Pain Interference with Therapy activities, balance deficit, daytime fatigue, #1 - Non-Observable Surgical Wound - Anterior Left Knee - , swell/redness surround. skin PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee - : Left knee surgical site: Remove Aquacel dressing on the 7th day post op and LOTA. Otherwise cover with a dry dressing if drainage occurs., cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision 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, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence	* 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 * 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 patient is adequately supervised caregiver administers and/or packages medications appropriately caregiver performs medical/rehabilitation treatments with adequate competence
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PT Careplans PT WK1: 1 (08/07/26-08/08/26) ,WK2: 3 (08/09/26-08/15/26) ,WK3: 2 (08/16/26-08/22/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 - Dyspnea, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower 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, 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, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand PROCEDURES: Medication management : Review medication with patient and family., cough/deep breathing exercises, incentive spirometer, home exercise program: Supine heelslides, quad sets, ankle pumps, seated laq, hip flexion, heelraises, heelslides, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training	PT Goals PATIENT-STATED GOAL: To improve my strength and walking drive again 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
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	08/07/2026

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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, 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 - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent			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 - 04. Supervision or touching assistance Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 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 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	

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