Home Health Certification and Plan of Care

Order ID: 1150/21279

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
24212320	08/13/2026	From: 08/13/2026 To: 10/11/2026	28396	217058

6. Patient's Name and Address

Douglas Shell
1061 Sansa Ct,
BEL AIR, MD 21014-
410-804-8811

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 03/11/1949 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	08/13/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	08/13/26
I10.	Essential (primary) hypertension	08/13/26
I95.1	Orthostatic hypotension	08/13/26
I34.0	Nonrheumatic mitral (valve) insufficiency	08/13/26
E78.00	Pure hypercholesterolemia unspecified	08/13/26
K21.9	Gastro-esophageal reflux disease without esophagitis	08/13/26
I70.0	Atherosclerosis of aorta	08/13/26
R13.10	Dysphagia unspecified	08/13/26
E02.	Subclinical iodine-deficiency hypothyroidism	08/13/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	08/13/26
Z85.828	Personal history of other malignant neoplasm of skin	08/13/26
Z79.82	Long term (current) use of aspirin	08/13/26
Z79.890	Hormone replacement therapy	08/13/26
Z86.0101	Personal history of adeno	08/13/26
Z97.4	Presence of external hearing-aid	08/13/26

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

Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, take 1 tablet by mouth every 4 hours As needed for pain.
Extra Strength Tylenol - Acetaminophen 500mg take 2 tablets by mouth every 6 hours As needed for pain.
Ibuprofen - Ibuprofen 600 mg Take 1 tablet by mouth three times a day As needed for pain.
Colace - Docusate Sodium 100mg. Take 1 tablet by mouth twice a day
COZAAR 100 mg tablet Oral daily
ASPIRIN 81mg, take 1 tablet Oral twice a day
VITAMIN 1 tablet Oral daily
PROTONIX eq 20 mg base take 1 tablet Oral daily 30 to 60 minutes before a meal
LORATADINE 10 mg Take 1 tablet Oral daily for allergy control
LIPITOR eq 40 mg base Take 1 tablet Oral daily
LEVOTHYROXINE 1 tablet Oral every morning 30 minutes before a meal
GLUCOSAMINE 1 tablet Oral by mouth
FLOMAX 0.4 mg Take 1 capsule Oral daily at bedtime

14. DME and Supplies:

walker, cane, bath bench

15. Safety Measures:

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

16. Nutrition:

low sodium

17. Allergies:

curare class

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Exercises Prescribed, Up As Tolerated, Walker

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:

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

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 77-year-old male with a past medical history significant for benign prostatic hyperplasia, mitral valve regurgitation, essential primary hypertension, orthostatic hypotension, gastroesophageal reflux disease (GERD), and other chronic medical conditions. The patient is status post elective left total knee replacement (L TKR) and returned home the same day of surgery with assistance from family. Upon assessment, the patient is alert and oriented to person, place, time, and situation (A&O x4) and resides with his wife, who serves as his primary caregiver. Mild postoperative swelling was noted to the left knee. The surgical incision is covered with an Aquacel dressing, with instructions for the dressing to remain in place until postoperative day 7, at which time it may be removed and the incision left open to air as directed. The patient ambulates with a walker and currently demonstrates postoperative pain, decreased left knee range of motion and strength, impaired balance, ambulatory dysfunction, and deficits in bed mobility and transfers. He requires assistance with mobility and is considered a high fall risk. Leaving the home requires a considerable and taxing effort due to his current postoperative functional limitations. Medication reconciliation and review were completed, and the patient was educated regarding medication compliance and adherence to the prescribed postoperative regimen. Skilled teaching was provided regarding appropriate use of ice for pain and edema management, proper lower-extremity positioning, prescribed therapeutic exercises, constipation prevention, and personal hygiene. The patient was also instructed on signs and symptoms of potential surgical-site infection, including increased redness, warmth, drainage, swelling, fever, or worsening pain, and verbalized understanding of the education provided. A home exercise program (HEP) was initiated, including ankle pumps, long arc quadriceps (LAQ) exercises, seated heel slides, quadriceps sets, and gluteal sets, with instruction to perform exercises as prescribed to promote strength, circulation, knee mobility, and functional recovery. Continued skilled physical therapy is indicated to address pain, decreased strength and range of motion, impaired balance, bed mobility and transfer deficits, gait dysfunction, and overall decreased functional independence. Without skilled PT intervention, the patient remains at risk for further functional decline, falls, complications related to immobility, and loss of independence. The plan of care is to continue skilled home health services with emphasis on postoperative monitoring, pain and edema management, progressive therapeutic exercise, gait and transfer training, balance activities, reinforcement of the HEP and safety precautions, and progression toward improved mobility and return to prior level of function.
 Date of Order 08/13/2026 Orders Physician Face-to-Face Date: 08/05/2026 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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 08/13/2026

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 : 08/05/2026

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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home
 1 - SOC - SN Notes: soc PT Eval Notes: eval
 Physician Huang, James

SN Careplans

SN WK1: 1 (08/13/26-08/15/26) ,WK2: 1 (08/16/26-08/22/26)

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: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, swelling of affected area (MS), muscle weakness (MS), limited endurance (MS), limited range of motion (MS), limited strength, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, balance deficit, #1 - Non-Observable Surgical Wound - Anterior Left Knee - Left knee replacement surgery, swell/redness surround. skin

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee - Left knee replacement surgery: Left knee surgical site: Remove Aquacel dressing on the left knee surgical site and leave open to air, otherwise cover with a dry gauze dressing 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, patient is adequately supervised, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: To walk without 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 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 is adequately supervised

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

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT Goals

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Messick, Charles RN

Date

08/13/2026

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PT WK1: 1 (08/13/26-08/15/26) ,WK2: 3 (08/16/26-08/22/26) ,WK3: 2 (08/23/26-08/29/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, M1400 - Dyspnea, 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, #2 - Non-Observable Surgical Wound - Anterior Left Knee - Non observable dressing

PROCEDURES: physician-ordered wound care: #2 - Non-Observable Surgical Wound - Anterior Left Knee - Non observable dressing, Medication management : Meds reviewed no changes, cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: Non remove able dressing, home exercise program: Supine SLR, QUAD SETS, HEELSLIDES , SEATED LAQ, HIP FLEXION, ANKLE PUMPS, SEATED HEELSLIDES 20 SECONDS , STANDING Tkes, equipment training, work simplification/energy conservation, 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, * 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, 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, Range of motion

PATIENT-STATED GOAL: I want to play tennis again

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
* 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

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

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Don/Doff Footwear - 06. Independent

Range of motion

Oral Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Sit to Stand - 06. Independent

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
08/13/2026