Home Health Certification and Plan of Care

Order ID: 1150/21721

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
83227827	09/01/2026	From: 09/01/2026 To: 10/30/2026	9629	217058

6. Patient's Name and Address

Brenda Goodwin
4342 Annapolis Rd,
Batimore, MD 21227-
410-370-2886

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 12/19/1956 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	09/01/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	09/01/26
F32.A	Depression unspecified	09/01/26
D32.0	Benign neoplasm of cerebral meninges	09/01/26
F41.9	Anxiety disorder unspecified	09/01/26
J44.9	Chronic obstructive pulmonary disease unspecified	09/01/26
F17.200	Nicotine dependence unspecified uncomplicated	09/01/26
M85.80	Oth disrd of bone density and structure unspecified site	09/01/26
E78.00	Pure hypercholesterolemia unspecified	09/01/26
H04.123	Dry eye syndrome of bilateral lacrimal glands	09/01/26
H02.836	Dermatochalasis of left eye unspecified eyelid	09/01/26
H02.833	Dermatochalasis of right eye unspecified eyelid	09/01/26
H26.9	Unspecified cataract	09/01/26
Z79.82	Long term (current) use of aspirin	09/01/26
Z87.891	Personal history of nicotine dependence	09/01/26

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

calcium carbonate/vitamin D2 (CALCIUM + VITAMIN D ORAL) 500 by mouth in the morning
Buspar - Buspirone Hydrochloride 15 mg 150mg by mouth twice a day Anxiety
Extra Strength Tylenol - Acetaminophen 500mg by mouth every 6 hours Pain and fever
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg by mouth every 4 hours Pain
Ibuprofen - Ibuprofen 600 mg by mouth every 6 hours Pain
Aspirin - Aspirin 81mg by mouth twice a day
Atorvastatin - Atorvastatin Calcium 20 by mouth at bedtime Hyperlipidemia

14. DME and Supplies:

walker

15. Safety Measures:

fall precautions, medication safety, knee precautions, ambulates with device, walker precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

chantix crestor pravastatin wellbutrin zocor

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

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: Yes

20. Prognosis: good

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

patient will be responsible for managing treatment

Homebound status: After undergoing Right 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:

Skilled nursing admission and physical therapy evaluation were completed for a 69-year-old female status post right total knee replacement (TKR) performed on 08/31/2026. The patient was discharged home from same-day surgery following the procedure with assistance from her daughter, Nicole. Past medical history is significant for hyperlipidemia, anxiety, and depression. The patient is alert and oriented 4 and has a hearing impairment. She lives alone but has a primary caregiver available during the daytime to assist with activities of daily living, and additional family members and neighbors are available to stay with or check on her as needed. Vital signs were assessed and were within acceptable parameters. The patient was observed wearing compression stockings for circulation, with no signs or symptoms of infection or postoperative complications noted at the time of assessment. She is tolerating movement and her toileting schedule. The surgical dressing remains in place, and the patient was instructed that skilled nursing will remove the dressing seven days post-procedure as ordered. Skilled nursing provided postoperative education to the patient and caregiver regarding infection prevention and precautions, including proper hand hygiene and recognition of signs and symptoms of infection or other complications requiring notification of the healthcare provider. Education included monitoring the incision for fever, chills, redness, increased swelling, worsening pain, bleeding, or drainage/discharge from the surgical site, as well as reporting persistent nausea or vomiting or pain that is not adequately relieved by prescribed medication. Medication reconciliation was completed, and education was provided regarding medication effects, potential adverse reactions, and safety precautions. The patient was specifically instructed regarding the constipating effects of pain medication and the importance of maintaining bowel regularity, with instructions to notify the appropriate healthcare provider if she has not had a bowel movement within three days. The patient and caregiver verbalized understanding of all education provided. Following the right TKR, the patient presents with decreased endurance, impaired mobility, decreased right knee strength, knee pain, impaired balance, unsteady gait, difficulty with transfers and stair negotiation, decreased safety awareness, and an increased risk for falls. The patient also has a history of falls. Due to these limitations, she requires assistance from another person and an assistive device to safely leave the home, supporting her homebound status. The patient resides in a home with one step required to enter and approximately 14 steps to access the second-floor bedroom and full bathroom. At present, she is remaining on the main level, sleeping in a recliner and utilizing the half bathroom available on that level due to her limited mobility and difficulty negotiating stairs. Physical therapy services were initiated to address the patient's postoperative functional deficits and promote safe progression toward independent mobility. The PT plan of care was discussed and developed with the patient and primary caregiver, and both were in agreement with the established plan. Home health physical therapy is planned at a frequency of 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh> per week for three weeks, beginning 08/31/2026, with the scheduled sequence of Tuesday/Wednesday, Tuesday/Thursday, and Monday/Tuesday <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-6 CE-FMS-visits">visits</mh>. The patient was instructed to arrange outpatient physical therapy services for continued rehabilitation following home health therapy and is scheduled to follow up with PA Hans on 09/16/2026. Education was provided regarding postoperative edema management, including the causes of edema and positioning strategies to reduce swelling. The patient was instructed to elevate the lower extremities above heart level during rest periods and to use compression garments only as recommended by the physician. The patient verbalized understanding. Infection prevention and incision monitoring were reinforced, including the need to promptly report fever, chills, increased redness, swelling, pain, bleeding, drainage, persistent nausea or vomiting, or worsening pain that is not relieved by medication. Transfer training was performed using the walker. The patient was instructed in proper hand and foot placement, forward weight shifting, controlled movement, and reaching back for the chair before sitting. She required minimal assistance to standby assistance for

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 09/01/2026

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 : 08/21/2026

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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safe transfers. The walker was adjusted to the appropriate height to improve safety and mechanics. Gait training was completed on level surfaces using the walker, with the patient requiring standby assistance. Verbal cues were provided for appropriate positioning within the walker, increased bilateral step height and step length, and overall safety. The patient was instructed to use the walker at all times during ambulation to reduce fall risk. Therapeutic exercise was initiated in the supine position, including ankle pumps, quadriceps sets, and gluteal sets, 1 set of 20 repetitions each, as well as heel slides, 1 set of 10 repetitions. A written home exercise program was left in the home, and the patient was instructed to complete the prescribed exercises twice daily as tolerated. Passive range of motion (PROM) of the right knee was also performed in the supine position. The patient was educated regarding the importance of frequent, safe ambulation following surgery to promote circulation, improve functional mobility, and reduce complications associated with prolonged inactivity. She was instructed to begin with short walks in the home every one to two hours while awake, initially completing one to two short bouts and progressing gradually as tolerated, with longer walking periods initially limited to approximately three to five minutes and increased progressively according to tolerance. Pain was reported to be well controlled with the current medication regimen. The patient was instructed regarding effective pain-management strategies, including taking prescribed pain medication at the onset of pain rather than waiting until pain becomes severe, while monitoring for potential adverse effects such as dizziness and constipation. She was instructed to seek emergency medical assistance or notify the appropriate provider for chest pain, shortness of breath, or pain that remains uncontrolled despite medication. The patient was also advised to take prescribed pain medication approximately one hour before physical therapy sessions when appropriate to facilitate participation and tolerance of therapeutic interventions. The patient verbalized understanding through teach-back. The patient was instructed to apply ice to the right knee for approximately 20 minutes at a time using an appropriate protective barrier between the ice and skin and to monitor the skin at approximately five-minute intervals for adverse skin changes. Continued skilled nursing and home health physical therapy are medically necessary to monitor postoperative recovery, reinforce medication and infection-prevention education, manage postoperative symptoms, improve right knee strength and range of motion, increase endurance, improve transfers and gait, progress stair negotiation, enhance balance and safety awareness, and reduce the patient's risk of falls and further functional decline. Without continued skilled intervention, the patient remains at increased risk for falls, complications, loss of mobility, and loss of independence with functional activities.
 Date of Order 09/01/2026 Orders Physician Face-to-Face Date: 08/21/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Right 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 frequency WK1: 1 (09/01/26-09/05/26) ,WK2: 1 (09/06/26-09/12/26)

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: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 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:POLST (Physician Orders for Life-Sustaining Treatment)

09/08/2026 Problems : #1 - Non-Observable Surgical Wound - Anterior Right Knee -
Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea

SN Goals

PATIENT-STATED GOAL: No pain

GOALS
patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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 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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
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M2020 - Oral Med Management
abn cholesterol > 200 mg/dL
balance deficit
difficulty sleeping
daytime fatigue
muscle weakness
muscle spasms
limited endurance
limited strength
constipation
obesity
bruising/discoloration
B1000 - Vision Deficit
M2102c - Med Admin
D0160 - Depression
M2102f - Patient Supervision
M2102d - Caregiver Performs Treatment

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Knee -: 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., cough/deep breathing exercises, incentive spirometer, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange resources for vision-impaired

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 keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, 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

PT Careplans

PT frequency WK1: 3 (09/01/26-09/05/26) ,WK2: 2 (09/06/26-09/12/26) ,WK3: 1 (09/13/26-09/19/26)

09/01/2026 Problems : GG0170P1 - Picking Up Object
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
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170D1 - Sit to Stand
GG0170O1 - 12 Steps
GG0170N1 - 4 Steps
GG0170M1 - 1 - Step (curb)
GG0170K1 - Walk 150 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170I1 - Walk 10 Feet
GG0170G1 - Car Transfer
GG0170F1 - Toilet Transfer

PROCEDURES: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging. Seated-LAQ, hip flex, seated heel slides, operated knee flex with opposite LE assist Standing-Mini squat, heel/toe raise, hip flex, leg curls, operated leg up down on 1st step, 1st step lunge with quad set on extension., therapeutic modalities: Apply ice to R knee x 20 minutes with necessary barrier and skin assessments q 5 minutes., equipment training: Walker/cane, gait training/stair training, transfers training, assist with fall prevention: Teach falls risk reduction strategies

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06.

PT Goals

PATIENT-STATED GOAL: To be able to walk without pain and to be able to bend my knee

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Car Transfer - 06. Independent

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Sit to Stand - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
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Shower/Bathe Self - 06. Setup or clean up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 4 of 4
Optional Name/Signature of Nurse/Therapist: Electronically Signed by Messick, Charles RN	Date 09/01/2026