HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022017

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
53196935	09/10/2026	09/10/2026 - 11/08/2026	29385	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Stephen Bouma 762 S Mesa Rd MILLERSVILLE, MD 21108	Male	01/06/1952	443-306-6809
	Email		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI 1487113239		**Fax Number** 410-559-3002

Clinical Condition Requiring Homecare:

Skilled nursing admission and physical therapy evaluation were completed following the patient's left total knee replacement (TKR) performed on 09/09/2026, with same-day discharge home. The patient is a 74-year-old male with a past medical history significant for hypertension, hyperlipidemia (HLD), benign prostatic hyperplasia (BPH), obstructive sleep apnea (OSA), bladder cancer, and insomnia. The patient returned home with assistance from his son, Benjamin, who serves as the primary caregiver during the day. A tenant residing downstairs, Christina, is also available to provide assistance as needed. The patient is alert and oriented x4 and has a hearing impairment. He denies chest pain, fever, nausea, or vomiting. Vital signs were within acceptable parameters. Cardiopulmonary assessment was unremarkable, with lungs clear to auscultation. Abdomen was flat with normoactive bowel sounds, and last bowel movement was reported as yesterday. Pedal pulse was present. The patient is wearing compression stockings for circulation and edema management. No signs or symptoms of surgical-site infection or other postoperative complications were noted at the time of assessment. The patient is tolerating movement and following an established toileting schedule. Skilled nursing provided education to the patient and caregiver regarding postoperative infection prevention, including proper hand hygiene and recognition of signs and symptoms requiring prompt medical attention, such as fever, chills, increased redness, swelling, worsening pain, bleeding, or drainage from the surgical incision. Education also included reporting persistent nausea or vomiting and pain that is not adequately controlled with 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 regular bowel movements, with instructions to notify the provider if a bowel movement does not occur within three days.

Physician Statement on 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.

The patient and caregiver verbalized understanding of all education provided. The patient was instructed that skilled nursing will remove the postoperative dressing seven days following the procedure, according to the postoperative plan. The patient demonstrates decreased endurance and mobility following TKR, with impaired balance, weakness, pain, and difficulty with functional mobility that increase his risk for falls. Due to these limitations, the patient requires assistance from another person and use of an assistive device to safely leave the home, supporting homebound status. Physical therapy evaluation was completed. The patient presents with left knee pain, decreased left knee strength and functional mobility, difficulty with transfers and stair negotiation, unsteady gait, decreased balance, decreased safety awareness, and increased fall risk. Skilled home physical therapy is indicated to address these deficits through therapeutic exercise, gait and transfer training, balance activities, stair negotiation, functional mobility training, safety education, and progression toward independent function within the home. Without skilled PT intervention, the patient remains at risk for falls, further functional decline, and loss of independence. The physical therapy plan of care was discussed and developed with the patient, who agreed with the proposed plan. Home PT is scheduled to begin 09/10/2026 at a frequency of 1 visit during the first week, followed by 3 visits during the subsequent week and 2 visits during the following week, as documented in the established plan of care. The patient is scheduled to transition to outpatient physical therapy on 09/25/2026 and has a follow-up appointment with PA Mena on 09/23/2026. Education was provided regarding the causes and management of postoperative edema, including elevating the lower extremities above heart level during rest periods and using compression garments if recommended by the physician. The patient was instructed in safe transfer techniques using a walker, including proper hand and foot placement, forward weight shifting, and reaching back for the chair before sitting. The patient required standby assistance (SBA) to complete transfers safely. Gait training was performed on level surfaces using a walker, with SBA required for safety. Verbal cues were provided for proper positioning within the walker, increased bilateral step height and step length, and overall gait safety. The patient was instructed to use the walker at all times during ambulation. The importance of frequent, safe daily ambulation was reviewed to promote circulation, improve functional endurance, and reduce complications associated with prolonged inactivity. The patient was instructed to begin with short walks in the home every 1-2 hours as tolerated, initially completing approximately 1-2 short walks and gradually progressing walking duration from 3-5 minutes as tolerated. Therapeutic exercises were initiated, 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 (HEP) was left in the home, and the patient was instructed to perform the exercises twice daily as tolerated. Passive range of motion (PROM) of the left knee was also performed in the supine position. The patient was instructed to apply ice to the left knee for 20 minutes at a time using an appropriate protective barrier, with periodic skin assessments to monitor for adverse skin response. Pain was reported to be well controlled with the current medication regimen. Education was provided regarding effective pain management, including taking prescribed pain medication at the onset of pain as directed and monitoring for potential adverse effects such as dizziness and constipation. The patient was instructed to seek emergency medical attention for chest pain or shortness of breath and to notify the provider regarding unrelieved or worsening pain. The patient was also advised to take prescribed pain medication approximately one hour before scheduled physical therapy sessions, as appropriate and according to medication instructions, to facilitate participation in therapy. The patient verbalized understanding through teach-back. Continued skilled nursing and physical therapy services are indicated for postoperative monitoring, medication and infection-prevention education, wound/dressing management, pain and edema management, therapeutic exercise, gait and transfer training, fall prevention, safety education, and progression toward safe and independent functional mobility.

Date of Order
09/10/2026
Orders
Physician Face-to-Face Date: 08/28/2026
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

ICD-10 CM Principal Diagnosis: Z47.1. Aftercare following joint replacement surgery

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
Z96.652	Presence of left artificial knee joint	Doxycycline Hyclate (LYMEPAK) 100 MG Tablet / Take 2 tablets by mouth as directed one time FLOMAX 0.4 MG / 1 Capsule by mouth daily AMBIEN 10 MG / 1 Tablet by mouth at bedtime as needed for sleep TYLENOL 500 MG Tablet / Take 2 tablets by mouth every 6 hours for 72 hours LIPITOR 40 MG / 1 Tablet by mouth daily for cholesterol and heart protection ZYRTEC Take 10 MG Tablet by mouth daily Phenazopyridine (AZO-TABS) 95 MG Tablet / Take 2 tablets by mouth three times a day after meals as needed For 2 days Aspirin - Aspirin 81 by mouth twice a day
I10.	Essential (primary) hypertension	
E78.5	Hyperlipidemia unspecified	
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	
G47.33	Obstructive sleep apnea (adult) (pediatric)	
G47.00	Insomnia unspecified	
N52.8	Other male erectile dysfunction	
Z85.51	Personal history of malignant neoplasm of bladder	

Z86.0100	Personal history of colonic polyps
Z87.891	Personal history of nicotine dependence

Aspirin - Aspirin 81 by mouth twice a day

Prognosis fair	**Mental and Psychosocial 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
Functional Limitations Ambulation, Dyspnea With Minimal Exertion, Endurance,	**Activities Permitted** Walker, Up As Tolerated
DME & Supplies walker, hand held shower, grab bars, bath bench, cane, 4 wheeled walker	**Safety Measures** walker precautions, medication safety, knee precautions, fall precautions, bathroom safety, avoid temperature extremes, ambulates with device
Nutrition Z. NO PHYSICIAN-ORDERED DIET	**Allergies** aspirin

Advance Directives	Caregiver Status
POLST (s for Life-Sustaining Treatment)	2. Non-agency caregiver(s) need training/supportive services to provide assistance; 2. Non-agency caregiver(s) need training/supportive services to provide assistance
Rehabilitation Potential	**DISCHARGE PLAN:**
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.	SN: patient will be responsible for managing treatment PT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - SN

PT Eval: eval

SN CAREPLAN

SN frequency WK1: 1 (09/10/26-09/12/26),WK2: 1 (09/13/26-09/19/26)

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:POLST (Physician Orders for Life-Sustaining Treatment)

09/15/2026 Problems : #1 - Non-Observable Surgical Wound - Anterior Left Knee -
M1400 - Dyspnea
M2020 - Oral Med Management
abn cholesterol > 200 mg/dL
abnormal blood pressure
daytime fatigue
difficulty sleeping
balance deficit
swelling of affected area
limited strength

SN NARRATIVE

Skilled nursing admission completed for a Patient completed left knee replacement. PMH HLD, BPH, OSA. The patient was released from same day surgery after a right knee replacement. Patient is alert and oriented 4 with hearing impairment. She lives alone with primary caregiver during the day, providing assistance with daily care. Assessment completed with vital signs within acceptable parameters. Patient has on compression stockings for circulation. no signs or symptoms of infection or complications. Patient is able to tolerate movement and toilet schedule. Skilled nursing provided education to the patient and caregiver on infection precautions, including recognizing signs and symptoms of infection, and when to notify the provider. Instruction was also provided on proper hand hygiene. Patient and caregiver verbalized understanding of all teaching. Skilled nursing reconciled medical, education on effects and adverse reaction. Patient was educated on medication effects of constipation and the importance to move bowels within 3 day. Patient instructed sn will remove dressing seven day post procedure.

Skilled nursing admission completed for a Patient completed left knee replacement. PMH HLD, BPH, OSA. The patient was released from same day surgery after a right knee replacement. Patient is alert and oriented 4. Patient lives alone with primary caregiver during the day, providing assistance with daily care. Assessment completed with vital signs within acceptable parameters. Patient has on compression stockings for circulation. no signs or symptoms of infection or complications. Patient is able to tolerate movement and toilet schedule. Skilled nursing provided education to the patient and caregiver on infection precautions, including recognizing signs and symptoms of infection, and when to notify the provider. Instruction was also provided on proper hand hygiene. Patient and caregiver verbalized understanding of all teaching. Skilled nursing reconciled medical, education on effects and adverse reaction. Patient was educated on medication effects of constipation and the importance to move bowels within 3 day. Patient instructed sn will remove dressing seven day post procedure.

Skilled nursing admission completed for a Patient completed left knee replacement. Patient is a 74 year old male with PMH HTN, HLD, BPH, OSA, bladder cancer, Insomnia. The patient was released from same day surgery after a left knee replacement. Patient is alert and oriented 4. Patient denies chest pain, fever, nausea and vomitting. Patient lungs clear on auscultation abdomen flat with normoactive bowel sounds LBM yesterday. Pedal pulse present. Patient lives with son as primary caregiver during the day, providing assistance with daily care. Assessment completed with vital signs within acceptable parameters. Patient has on compression stockings for circulation. no signs or symptoms of infection or complications. Patient is able to tolerate movement and toilet schedule. Skilled nursing provided education to the patient and caregiver on infection precautions, including recognizing signs and symptoms of infection, and when to notify the provider. Instruction was also provided on proper hand hygiene. Patient and caregiver verbalized understanding of all teaching. Skilled nursing reconciled medical, education on effects and adverse reaction. Patient was educated on medication effects of constipation and the importance to move bowels within 3 day. Patient instructed sn will remove dressing seven day post procedure.

SN GOALS

PATIENT-STATED GOAL: Walk my dog 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

increased urine output constipation bruising/discoloration B1000 - Vision Deficit M2102c - Med Admin M2102f - Patient Supervision M2102d - Caregiver Performs Treatment PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left 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 TEACH PATIENT/CAREGIVER: * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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	* how to keep home safe for patient with vision loss including eliminating hazards * enhancing lighting * using mechanical aids patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule patient is adequately supervised caregiver administers and/or packages medications appropriately

Bouma, Stephen | Cert Period 09/10/26 - 11/08/26

PT CAREPLAN	PT NARRATIVE
PT frequency WK1: 1 (09/10/26-09/12/26),WK2: 3 (09/13/26-09/19/26),WK3: 2 (09/20/26-09/26/26)	After undergoing TKR pt is showing decreased endurance and mobility, increasing the likelyhood of falls. To safely leave their home the pt needs assistance from another person and an assistive device.
09/10/2026 Problems : GG0170N1 - 4 Steps 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 Pain Effect on Sleep 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 Pain Interference with ADLs Pain Interference with Therapy activities	PT evaluation completed. Pt is a 74 yo male who had a L TKR on 9/9/26, pt returned home the same day with the assistance son Benjamin. Pt has a tenant who lives downstairs to provide assistance, Christina. To safely leave their home the pt needs assistance from another person and an assistive device. Pt presents with the following deficits, knee pain, decreased strength in knee, decreased functional mobility, difficulty with negotiating steps, unsteady gait, difficulty with transfers, decreased balance, decreased safety awareness, increased risk for falls. Pt will benefit from home PT services to improve strength, functional mobility, transfers, safety with ambulation, steps, balance, and safety awareness to restore independent function at home. Without skilled PT pt is at a risk for falls, further functional decline, and loss of independence.
PROCEDURES: home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging.	Discussed and developed PT POC with pt, pt in agreement with PT POC. Pt to be seen for home PT with frequency beginning 9/10.26 1w1, 3w1 (mon/tue/th,), (2w1 Mon/wed) pt will start out patient PT on 9/25/26, will f/u with PA Mena on 9/23/26.
Seated-LAQ, hip flex, seated heel slides, operated knee flex with opposite LE assist	Instructed pt/PCG on what causes edema, and positional strategies to decrease edema, to include elevating LEs above heart during rest periods and use of compression garments if recomended by MD. Pt verbalized understanding of instructions provided.
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 L knee x 20 minutes with necessary barrier and skin assessments q 5 minutes., equipment training: walker/cane, gait training on uneven surfaces, gait training/stair training, transfers training	Reviewed signs and symptoms of infection of incision/wound, including fever, chills, redness, swelling, pain, bleeding, or any discharge from the surgical site. Nausea or vomiting that does not get better, or pain that does not get better with medication.
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, Sit to Stand - 06. Independent, Chair to Bed to Chair - 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 - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent	From pg 32-33 of the pt handbook instructed pt in home safety, preventing falls, risk factors for falls, and home safety measures to decrease the risk for falls.
	Pt instructed in safe transfers using walker, cues for proper hand/foot placement and fwd wt shift, also for reach back to chair prior to sitting down, pt requiring SBA to safely transfer.
	Pt instructed in and performed supine therex, ankle pump, quad set, gluteal set, 1 x 20, heel slide, 1 x 10, copy of HEP left in home with instructions to complete twice daily.
	Performed PROM of L knee in supine position.
	Pt instructed in safe ambulation skills on level surfaces with walker, pt required sba to safely walk with walker, provided cues for position in walker, increased bilateral step height and length and for safety. Recomended that pt walk with walker at all times.
	Pt educated on importance and benefits of daily ambulation, including improved blood circulation and prevention of complications due to inactivity. Instructed to start a walking program with short walks every 1-2 hours in the home, 1-2x, long walks to start 3-5 min then slowly progress as tolerated.
	Pt instructed to apply ice to L knee x 20 minutes with necessary barrier and skin assessments q 5 minutes.
	Pain well controlled with current meds. Pt instructed on effective pain management, to take pain meds at start of pain, watch for dizzyness and constipation as s/e of pain meds, call 911/EMS or provider for chest pain, unrelieved pain or SOB. Also recomended pt take pain medications 1 hour prior to all PT . Pt VU via TB.

PT evaluation completed. Pt is a 74 yo male who had a L TKR on 9/9/26, pt returned home the same day with the assistance son Benjamin. Pt has a tenant who lives downstairs to provide assistance, Christina. To safely leave their home the pt needs assistance from another person and an assistive device. Pt presents with the following deficits, knee pain, decreased strength in knee, decreased functional mobility, difficulty with negotiating steps, unsteady gait, difficulty with transfers, decreased balance, decreased safety awareness, increased risk for falls. Pt will benefit from home PT services to improve strength, functional mobility, transfers, safety with ambulation, steps, balance, and safety awareness to restore independent function at home. Without skilled PT pt is at a risk for falls, further functional decline, and loss of independence.

Discussed and developed PT POC with pt, pt in agreement with PT POC. Pt to be seen for home PT with frequency beginning 9/10.26 1w1, 3w1 (mon/tue/th,), (2w1 Mon/wed) pt will start out patient PT on 9/25/26, will f/u with PA Mena on 9/23/26.

Instructed pt/PCG on what causes edema, and positional strategies to decrease edema, to include elevating LEs above heart during rest periods and use of compression garments if recomended by MD. Pt verbalized understanding of instructions provided.

Reviewed signs and symptoms of infection of incision/wound, including fever, chills, redness, swelling, pain, bleeding, or any discharge from the surgical site. Nausea or vomiting that does not get better, or pain that does not get better with medication.

From pg 32-33 of the pt handbook instructed pt in home safety, preventing falls, risk factors for falls, and home safety measures to decrease the risk for falls.

Pt instructed in safe transfers using walker, cues for proper hand/foot placement and fwd wt shift, also for reach back to chair prior to sitting down, pt requiring SBA to safely transfer.

Pt instructed in and performed supine therex, ankle pump, quad set, gluteal set, 1 x 20, heel slide, 1 x 10, copy of HEP left in home with instructions to complete twice daily.

Performed PROM of L knee in supine position.

Pt instructed in safe ambulation skills on level surfaces with walker, pt required sba to safely walk with walker, provided cues for position in walker, increased bilateral step height and length and for safety. Recomended that pt walk with walker at all times.

Pt educated on importance and benefits of daily ambulation, including improved blood circulation and prevention of complications due to inactivity. Instructed to start a walking program with short walks every 1-2 hours in the home, 1-2x, long walks to start 3-5 min then slowly progress as tolerated.

Pt instructed to apply ice to L knee x 20 minutes with necessary barrier and skin assessments q 5 minutes.

Pain well controlled with current meds. Pt instructed on effective pain management, to take pain meds at start of pain, watch for dizzyness and constipation as s/e of pain meds, call 911/EMS or provider for chest pain, unrelieved pain or SOB. Also recomended pt take pain medications 1 hour prior to all PT . Pt VU via TB.

PT evaluation completed. Pt is a 74 yo male who had a L TKR on 9/9/26, pt returned home the same day with the assistance son Benjamin. Pt has a

tenant who lives downstairs to provide assistance, Christina. To safely leave their home the pt needs assistance from another person and an assistive device. Pt presents with the following deficits, knee pain, decreased strength in knee, decreased functional mobility, difficulty with negotiating steps, unsteady gait, difficulty with transfers, decreased balance, decreased safety awareness, increased risk for falls. Pt will benefit from home PT services to improve strength, functional mobility, transfers, safety with ambulation, steps, balance, and safety awareness to restore independent function at home. Without skilled PT pt is at a risk for falls, further functional decline, and loss of independence.

Discussed and developed PT POC with pt, pt in agreement with PT POC. Pt to be seen for home PT with frequency beginning 9/10.26 1w1, 3w1 (mon/tue/th,), (2w1 Mon/wed) pt will start out patient PT on 9/25/26, will f/u with PA Mena on 9/23/26.

Instructed pt/PCG on what causes edema, and positional strategies to decrease edema, to include elevating LEs above heart during rest periods and use of compression garments if recomended by MD. Pt verbalized understanding of instructions provided.

Reviewed signs and symptoms of infection of incision/wound, including fever, chills, redness, swelling, pain, bleeding, or any discharge from the surgical site. Nausea or vomiting that does not get better, or pain that does not get better with medication.

From pg 32-33 of the pt handbook instructed pt in home safety, preventing falls, risk factors for falls, and home safety measures to decrease the risk for falls.

Pt instructed in safe transfers using walker, cues for proper hand/foot placement and fwd wt shift, also for reach back to chair prior to sitting down, pt requiring SBA to safely transfer.

Pt instructed in and performed supine therex, ankle pump, quad set, gluteal set, 1 x 20, heel slide, 1 x 10, copy of HEP left in home with instructions to complete twice daily.

Performed PROM of L knee in supine position.

Pt instructed in safe ambulation skills on level surfaces with walker, pt required sba to safely walk with walker, provided cues for position in walker, increased bilateral step height and length and for safety. Recomended that pt walk with walker at all times.

Pt educated on importance and benefits of daily ambulation, including improved blood circulation and prevention of complications due to inactivity. Instructed to start a walking program with short walks every 1-2 hours in the home, 1-2x, long walks to start 3-5 min then slowly progress as tolerated.

Pt instructed to apply ice to L knee x 20 minutes with necessary barrier and skin assessments q 5 minutes.

Pain well controlled with current meds. Pt instructed on effective pain management, to take pain meds at start of pain, watch for dizzyness and constipation as s/e of pain meds, call 911/EMS or provider for chest pain, unrelieved pain or SOB. Also recomended pt take pain medications 1 hour prior to all PT . Pt VU via TB.

PT GOALS
PATIENT-STATED GOAL: To be able to walk independently

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

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

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

Car Transfer - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Sit to Stand - 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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Upper Body Dressing - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/10/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services. F2F date: 08/28/2026	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.
Certifying Physician or Allowed Practitioner Name and Address **James Huang** 8028 Ritchie Hwy Pasadena, MD 21122 NPI 1154567709	**Phone Number** 410-737-5600 **Fax Number** 14107375391

Physician's Signature and Date Signed

X

James Huang
08/28/2026: Date of physician last face-to-face