Home Health Certification and Plan of Care

Order ID: 1150/20510

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
531304452	07/12/2026	From: 07/12/2026 To: 09/09/2026	26490	217058

6. Patient's Name and Address

Amtul Malik
5876 Stevens Forest Rd Apt 1,
COLUMBIA, MD 21045-
410-245-3403

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 10/27/1946 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	07/12/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.651	Presence of right artificial knee joint	07/12/26
M17.12	Unilateral primary osteoarthritis left knee	07/12/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	07/12/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	07/12/26
N18.4	Chronic kidney disease stage 4 (severe)	07/12/26
I35.0	Nonrheumatic aortic (valve) stenosis	07/12/26
E11.319	Type 2 diabetes w unsp diabetic rtnop w/o macular edema	07/12/26
E78.5	Hyperlipidemia unspecified	07/12/26
I70.0	Atherosclerosis of aorta	07/12/26
G47.00	Insomnia unspecified	07/12/26
E66.9	Obesity unspecified	07/12/26
Z68.38	Body mass index [BMI] 38.0-38.9 adult	07/12/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	07/12/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	07/12/26
Z79.82	Long term (current) use of aspirin	07/12/26
Z90.710	Acquired absence of both cervix and uterus	07/12/26
Z87.01	Personal history of pneumonia (recurrent)	07/12/26

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

Nephro-Vite - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 0.8mg; 1 tab by mouth in the morning supplement
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg; 1 tab by mouth every 4 hours as needed for pain
Trazadone - Trazodone Hydrochloride 50mg; 1 tab by mouth at bedtime for insomnia
Acetaminophen - Acetaminophen 500mg; 2 tabs by mouth every 8 hours for pain
ASPIRIN 0 DR 81 MG / 1 Tablet by mouth twice a day dvt prophylasix
LIPITOR eq 10 mg base 10 MG / 1 Tablet by mouth daily cholesterol
Carvedilol - Carvedilol 3.125 mg 3.125mg; 1 tab by mouth twice a day HTN
Cephalexin - Cephalexin eq 500 mg base 500MG; 1CAP by mouth every 8 hours FOR RIGHT KNEE SURGICAL WOUND INFECTION LAST DOSE 7/13/26
Colace - Docusate Sodium 100MG; 1 CAP by mouth every 12 hours AS NEEDED FOR CONSTIPATION
Glipizide - Glipizide 10 mg 10MG; 1 TAB by mouth in the morning DM2
Glipizide - Glipizide 5 mg 5MG; 1 TAB by mouth at bedtime DM2
Hydralazine - Hydralazine Hydrochloride 25MG; 1 TAB by mouth once a day HTN
JARDIANCE 25 mg/tablet / Take half tablet by mouth once a day DM2
Losartan Potassium - Losartan Potassium 100 mg 100MG; 1 TAB by mouth once a day HTN
semaglutide (OZEMPIC) 0.25 mg or 0.5 mg (2 mg/3 mL) SubQ Pen Injector
Inject 0.25 mg subcutaneous once a week every 7 days

14. DME and Supplies:

grab bars, wheelchair, bath bench, walker, cane

15. Safety Measures:

standard precautions, knee precautions, fall precautions, bleeding precautions, ambulates with device, walker precautions, medication safety, transfer with assist, supervision at all times, anticoagulant precautions, activity supervision

16. Nutrition:

low cholesterol, low sodium, diabetic, ,

17. Allergies:

lisinopril

18.A. Functional Limitations

Endurance, Ambulation

18.B. Activities Permitted

Cane, Walker, Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, 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: 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

family/caregiver will be responsible for managing treatment
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:

The patient is a 79-year-old female referred to home health services following a right total knee replacement performed on 06/18. Her postoperative course was complicated by acquired right lower lobe pneumonia and elevated blood glucose levels, requiring hospitalization and discharge to a skilled nursing facility prior to returning home. Her past medical history is significant for bilateral knee osteoarthritis, aftercare following joint replacement surgery, type 2 diabetes mellitus, chronic kidney disease stage 4, essential hypertension, hyperlipidemia, morbid obesity, insomnia, chronic right knee pain, and the presence of a right artificial knee joint. The patient resides alone, with two sons living nearby who provide transportation, grocery shopping, and assistance with laundry. Family members assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed. During the Skilled Nursing assessment, the patient was alert and oriented 3 and ambulating with a rolling walker for safety. She reported right knee pain rated 4/10 and had taken acetaminophen (Tylenol) prior to the visit with adequate relief. She denied shortness of breath, although auscultation revealed diminished breath sounds in the right lower lobe consistent with her recent diagnosis of pneumonia. The patient reported a good appetite, her last bowel movement occurred the previous day, and she complained of frequent urination. Assessment revealed bilateral lower extremity +2 edema. Inspection of the right knee surgical incision demonstrated a closed incision measuring 16.0 cm in length with scab formation and mild surrounding erythema. No drainage or other signs of wound complications were observed. The patient continues treatment with Glipizide, Jardiance, and weekly Ozempic for diabetes management. Skilled Nursing reviewed all medications, including indications, dosages, administration schedules, and potential side effects. Education was also provided regarding proper closed incision care, effective pain management techniques, blood glucose monitoring, recognition of signs and symptoms of infection, edema management, fall prevention, and the importance of medication adherence. The patient and caregiver verbalized understanding of all teaching provided. Skilled Nursing services are ordered at a frequency of one visit weekly for two weeks (1W2) to provide ongoing assessment, cardiopulmonary monitoring, wound surveillance, medication management, and continued patient education. A Physical Therapy evaluation revealed postoperative weakness and delayed functional recovery following discharge from the skilled nursing facility. The patient demonstrates right lower extremity weakness, decreased right knee range of motion, impaired balance, reduced endurance, altered gait mechanics, and an increased risk for falls. She requires the use of a rolling walker for safe ambulation and continues to experience limitations in transfers and functional mobility. Skilled Physical Therapy is medically necessary to address lower extremity strengthening, therapeutic exercise, range of motion restoration, gait training, balance training, stair negotiation, transfer safety, endurance training, fall prevention, and progression toward her prior level of function. An Occupational Therapy evaluation further identified deficits in self-care and functional independence. The patient currently requires standby to minimal assistance with basic activities of daily living

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 07/12/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Mohammad Rana
1447 York Rd
Lutherville, MD 21093
PHONE: FAX: NPI: 1134278773

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 : 07/01/2026

27. Attending Physician's Signature and Date Signed **07/20/2026**: 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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and continues to rely on family support for instrumental activities of daily living. Functional limitations related to postoperative pain, decreased standing tolerance, impaired balance, reduced activity tolerance, and generalized weakness negatively impact her ability to safely perform daily tasks. Skilled Occupational Therapy is medically necessary to improve independence with ADLs, increase standing tolerance and endurance, implement energy conservation and safety strategies, recommend adaptive techniques and equipment as appropriate, and reduce fall risk to maximize the patient's functional independence and support a safe recovery at home. The interdisciplinary plan of care includes ongoing Skilled Nursing, Physical Therapy, and Occupational Therapy services to monitor recovery, manage chronic comorbidities, promote wound healing, improve functional mobility, restore independence, and reduce the risk of complications and rehospitalization.
 Date of Order 07/12/2026 Orders Physician Face-to-Face Date: 07/01/2026 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: OT Eval Notes:
 Physician Rana, Mohammad

SN Careplans

SN WK1: 1 (07/12/26-07/18/26) ,WK2: 1 (07/19/26-07/25/26) ,WK3: 1 (07/26/26-08/01/26) ,WK4: 1 (08/02/26-08/08/26) ,WK5: 1 (08/09/26-08/15/26) ,WK6: 1 (08/16/26-08/22/26) ,WK7: 1 (08/23/26-08/29/26) ,WK8: 1 (08/30/26-09/05/26)

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: 3. Multiple hospitalizations (2 or more) in the past 6 months, 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, lung sounds not clear, dependent edema, M1033 - Exhaustion, M1400 - Dyspnea, limited range of motion, swelling of affected area, limited endurance, limited strength, balance deficit, Pain Interference with Therapy activities, Pain Interference with ADLs, obesity, swell/redness surround. skin, #1 - Other - Anterior Right Knee - OPEN TO AIR

PROCEDURES: physician-ordered wound care: #1 - Other - Anterior Right Knee - OPEN TO AIR: RIGHT KNEE OPEN TO AIR, cough/deep breathing exercises

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

SN Goals

PATIENT-STATED GOAL: TO GET BETTER

GOALS
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

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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

meal preparation is available to patient for all meals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/12/2026

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cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

PT Careplans

PT WK1: 1 (07/12/26-07/18/26) ,WK2: 2 (07/19/26-07/25/26) ,WK3: 1 (07/26/26-08/01/26) ,WK4: 1 (08/02/26-08/08/26) ,WK5: 1 (08/09/26-08/15/26) ,WK6: 1 (08/16/26-08/22/26) ,WK7: 1 (08/23/26-08/29/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair

PROCEDURES: B LE mm strengthening: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day., gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 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

PT Goals

PATIENT-STATED GOAL: To walk safer at home

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 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

OT Careplans

OT WK1: 1 (07/12/26-07/18/26) ,WK2: 1 (07/19/26-07/25/26) ,WK3: 1 (07/26/26-08/01/26) ,WK4: 1 (08/02/26-08/08/26) ,WK5: 1 (08/09/26-08/15/26) ,WK6: 1 (08/16/26-08/22/26) ,WK7: 1 (08/23/26-08/29/26) ,WK8: 1 (08/30/26-09/05/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing

PROCEDURES: Improve standing tolerance: Standing tolerance for 7 mins or more, cough/deep breathing exercises, incentive spirometer, home exercise program: Exes for UE, functional ambulation and deep breathing exes, equipment training, work simplification/energy conservation

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, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: Be able to do daily routine

GOALS
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

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/12/2026