

Home Health Certification and Plan of Care				Order ID: 1150/20515	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
18263985		07/14/2026		From: 07/14/2026 To: 09/11/2026	
4. Medical Record No.			5. Provider No.		
27345			217058		
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Claire Compton 4909 Grindon Ave, BALTIMORE, MD 21214- 334-413-3522			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
11/12/1975			Female		
11. ICD		Principal Diagnosis		Date	
Z47.1		Aftercare following joint replacement surgery		07/14/26	
13. ICD		Other Pertinent Diagnoses		Date	
Z96.652		Presence of left artificial knee joint		07/14/26	
G47.33		Obstructive sleep apnea (adult) (pediatric)		07/14/26	
L85.8		Other specified epidermal thickening		07/14/26	
E66.9		Obesity unspecified		07/14/26	
Z68.35		Body mass index [BMI] 35.0-35.9 adult		07/14/26	
Z87.891		Personal history of nicotine dependence		07/14/26	
14. DME and Supplies:			15. Medications: Dose/Frequency/Route (N)ew (C)hanged		
walker, hand held shower, bath bench			TYLENOL 500mg=1tablet by mouth every 8 hours Take 2 tablets every 8 hours as needed for pain Aspirin 81Mg - Aspirin 81mg=1tablet by mouth twice a day Oxaydo - Oxycodone Hydrochloride 5mg=1tablet by mouth every 4 hours As needed for pain Vitamin B1 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 50mg=1tablet by mouth once a day Colace - Docusate Sodium 100mg=1tablet by mouth twice a day		
16. Nutrition:			17. Allergies:		
Z. NO PHYSICIAN-ORDERED DIET			no known allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
Endurance, Ambulation			Transfer bed/Chair, Exercises Prescribed, Walker, , Up As Tolerated		
19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No					
20. Prognosis: Good					
22. A Rehabilitation Potential:			22.B.Discharge Plans		
SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.			patient will be responsible for managing treatment 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: <div>The patient is a 50-year-old female admitted to home health services following a left total knee replacement. Her past medical history is significant for obstructive sleep apnea, prediabetes, obesity, osteoarthritis of both lower extremities, and status post bariatric (gastric sleeve) surgery. The patient lives alone in a single-family home with five steps and a handrail at the entrance, while the bedroom and bathroom are located on the second floor, presenting additional mobility challenges during her postoperative recovery. The patient is alert and oriented 4, pleasant, and able to communicate her needs appropriately. Vital signs were obtained and were within normal limits. She reports postoperative left knee pain that is adequately managed with prescribed analgesics. Skilled nursing assessment was completed, revealing the left knee surgical dressing to be clean, dry, and intact, with no evidence of infection, excessive drainage, wound dehiscence, or dressing compromise. Medication reconciliation was performed, and all medications were reviewed for accuracy. Education was provided regarding medication adherence, indications, dosing, potential side effects, and the importance of taking medications as prescribed. The patient ambulates approximately 30 feet twice on level indoor surfaces using a rolling walker with supervision and requires assistance due to recent surgery and impaired mobility. She is able to negotiate four steps using a handrail and cane while descending backward with supervision. Transfers to and from the bed, chair, and toilet are performed with supervision, while bed mobility requires minimal assistance for management of the left lower extremity. Outside ambulation and car transfer were not assessed during this visit. The patient is considered homebound due to the significant effort required to leave the home with an assistive device, as evidenced by a Tinetti Balance Assessment score of 14/28, indicating an increased risk for falls. During the therapy session, the patient tolerated a postoperative therapeutic exercise program consisting of supine quadriceps sets, short arc quadriceps exercises, hip flexion, straight leg raises with assistance, hip abduction, knee extension, and ankle pumps, completing 10 repetitions of each exercise. Left knee range of motion measured 5 to 75 degrees. Education was provided regarding pain management, including the appropriate use of prescribed pain medication, non-pharmacologic pain relief strategies, and monitoring for medication side effects. Fall prevention education emphasized proper use of the rolling walker, maintaining a clutter-free environment, wearing non-skid footwear, and requesting assistance when needed. The patient was also instructed to monitor for signs and symptoms of surgical site infection, including increased redness, swelling, warmth, drainage, fever, or worsening pain, and to notify the surgeon or healthcare provider immediately should these occur. The patient demonstrated understanding of all education provided. The patient continues to require skilled nursing services for ongoing postoperative assessment, surgical wound monitoring, pain management, medication education, and reinforcement of safety precautions to promote healing and prevent complications. Continued home physical therapy is medically necessary to improve left lower extremity strength, increase knee range of motion, enhance gait, transfer ability, stair negotiation, and functional mobility, with the goal of returning the patient to her highest level of independence and safety within the home environment.</div><div>Date of Order</div><div>07/14/2026</div><div>Orders</div><div>Physician Face-to-Face Date: 07/08/2026</div><div>Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left total knee replacement</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div>1 - SOC - SN Notes: soc</div><div>PT Eval Notes: eval</div><div>Huang, James</div></div>					
SN Careplans			SN Goals		
23. Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT		
Electronically Signed by Messick, Charles RN on 07/14/2026					
24. Physician's Name and Address			26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.		
James Huang 8028 Ritchie Hwy Pasadena, MD 21122 PHONE: 410-737-5600 FAX: 14107375391 NPI: 1154567709			F2F date : 07/08/2026		
27. Attending Physician's Signature and Date Signed			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.		
Date of physician last face-to-face			PAGE 1 of 3		

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SN WK1: 1 (07/14/26-07/18/26) ,WK2: 1 (07/19/26-07/25/26) 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:No Advance Directive PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, M2102f - Patient Supervision, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, M1400 - Dyspnea, limited endurance, limited strength, limited range of motion, B1000 - Vision Deficit, Pain Interference with ADLs, Pain Effect on Sleep, balance deficit, #1 - Non-Observable Surgical Wound - Other - Left knee - , bruising/discoloration, swell/redness surround. skin PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Other - Left knee -, cough/deep breathing exercises, incentive spirometer, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals, 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 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's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence	PATIENT-STATED GOAL: Patient stated she would like to heal properly from surgery without difficulty 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 * 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's transportation needs are met patient is adequately supervised meal preparation is available to patient for all meals caregiver administers and/or packages medications appropriately caregiver performs medical/rehabilitation treatments with adequate competence
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PT Careplans	PT Goals
Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	07/14/2026

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PT WK1: 3 (07/14/26-07/18/26) ,WK2: 3 (07/19/26-07/25/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Effect on Sleep, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130B1 - Oral Hygiene, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170P1 - Picking Up Object, 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, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand PROCEDURES: Stretching to left knee. Original ROM 5-75 degrees: 5x hold 10 seconds, home exercise program: Quad sets, short arc quads, hip flexion, straight leg raise, hip abduction. Sitting knee extension, ankle pumps. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats, equipment training, gait training/stair training, transfers training 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, Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet 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, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 02. Substantial/maximal assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 05. Setup or clean-up assistance, Upper Body Dressing - 06. Independent		PATIENT-STATED GOAL: To be independent with a cane outside and return to driving GOALS Toilet Transfer - 06. Independent 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 Walk 150 Feet - 04. Supervision or touching assistance 1 - Step (curb) - 04. Supervision or touching assistance Picking Up Object - 04. Supervision or touching assistance Car Transfer - 05. Setup or clean-up 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 - 05. Setup or clean-up assistance Chair to Bed to Chair - 05. Setup or clean-up assistance Walk 10 Feet - 04. Supervision or touching assistance Walk 50 ft with 2 Turns - 04. Supervision or touching assistance 4 Steps - 04. Supervision or touching assistance 12 Steps - 04. Supervision or touching assistance Shower/Bathe Self - 02. Substantial/maximal assistance Eating - 05. Setup or clean-up assistance Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Upper Body Dressing - 06. Independent		

Signature of Physician:	Date
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