Home Health Certification and Plan of Care

Order ID: 1150/17895

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
33116920	04/10/2026	From: 04/10/2026 To: 06/08/2026	24008	217058

6. Patient's Name and Address

Deborah Epps
3522 Dudley Ave,
BALTIMORE, MD 21213-
443-474-1325

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 04/08/1961 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	04/10/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.653	Presence of artificial knee joint bilateral	04/10/26
M19.041	Primary osteoarthritis right hand	04/10/26
M19.042	Primary osteoarthritis left hand	04/10/26
M54.16	Radiculopathy lumbar region	04/10/26
G89.29	Other chronic pain	04/10/26
E11.9	Type 2 diabetes mellitus without complications	04/10/26
I10.	Essential (primary) hypertension	04/10/26
J45.909	Unspecified asthma uncomplicated	04/10/26
J30.2	Other seasonal allergic rhinitis	04/10/26
E78.5	Hyperlipidemia unspecified	04/10/26
K21.9	Gastro-esophageal reflux disease without esophagitis	04/10/26
E55.9	Vitamin D deficiency unspecified	04/10/26
E66.9	Obesity unspecified	04/10/26
Z68.32	Body mass index [BMI] 32.0-32.9 adult	04/10/26
Z79.4	Long term (current) use of insulin	04/10/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	04/10/26

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

ECOTRIN 81 MG mg Oral Take 1 tablet by mouth daily
INSULIN 100 unit/mL Subcutaneous Inject 28 Units subcutaneously daily
TOPROL 50 MG mg Oral Take 1 tablet by mouth daily
NORVASC 10 MG mg Oral Take 1 tablet by mouth daily
LIPITOR 20 MG mg Oral Take 1 tablet by mouth daily **THIS REPLACES SIMVASTATIN**
TYLENOL 500 MG mg Oral Take 2 tablets by mouth every 6 hours as needed for pain
lancets (ONETOUCH DELICA PLUS LANCET) 30 gauge Misc Ndle 30 g Use to check blood glucose 2 times a day
BIOTIN Oral Take 1 tablet by mouth daily
Pen needle, diabetic (SURE COMFORT PEN NEEDLE) 32 gauge x 5/32" Misc Needle - as necessary Pen needle, diabetic (SURE COMFORT PEN NEEDLE) 32 gauge x 5/32" Misc Needle
Use as directed
COZAAR 100 mg mg Take 1 tablet by mouth daily for blood pressure
Liragutide 18mg/3m subcutaneous once a day Inject 12 units every morning subcutaneously
Aspirin - Aspirin 81mg=1tablet by mouth once a day
Oxaydo - Oxycodone Hydrochloride 5mg=1tablet by mouth every 4 hours Take 1 to 2 tablet every 4 hours as needed for pain
Colace - Docusate Sodium 100mg=1tablet by mouth twice a day
Xyzal - Levocetirizine Dihydrochloride 5mg=1tablet by mouth once a day
Metoprolol - Hydrochlorothiazide: Metoprolol Succinate 25mg=1tablet by mouth once a day

14. DME and Supplies:

walker, , hand held shower

15. Safety Measures:

walker precautions, smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with device, ambulates with assistance, hand rails, knee precautions, medication safety, transfer with assist, fall precautions, diabetic precautions, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

ace inhibitors clonidine kelp metformin morphine shellfish sulfa antibiotics

18.A. Functional Limitations

None of the above

18.B. Activities Permitted

Up As Tolerated, Walker, Exercises Prescribed, Transfer bed/Chair

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:

SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

22.B.Discharge Plans

patient will be responsible for managing treatment
family/caregiver 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 was completed for a 65-year-old female referred to home health services following a recent right total knee replacement. The patient's past medical history is significant for type 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-diabetes">diabetes</mh> mellitus without complications, chronic low back pain with lumbar radiculopathy, bilateral knee osteoarthritis, prior left knee replacement, <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-10 CE-FMS-hyperlipidemia">hyperlipidemia</mh>, and asthma. Upon assessment, the patient was alert and oriented to person, place, and time, cooperative, and in no acute distress. She denied pain at the time of the visit. Vital signs were obtained and found to be within normal limits. Cardiopulmonary assessment was unremarkable, with regular heart rate and rhythm and clear lung sounds bilaterally. The surgical site to the right knee was observed with the dressing in place, which was clean, dry, and intact, with no signs or symptoms of infection such as redness, warmth, swelling, or drainage. The patient demonstrates limited mobility consistent with her recent surgical procedure but is able to ambulate indoors using a rolling walker for approximately 30 feet twice with supervision and verbal cues for proper gait pattern. She is able to negotiate 14 steps using a handrail and cane with supervision. Bed mobility is performed with supervision, utilizing her upper extremities to assist in lifting and positioning the right lower extremity. Transfers from sitting to standing from the sofa, bed, and toilet are performed with supervision. Outdoor mobility and car transfer abilities were not assessed during this visit. Range of motion of the right knee was measured from 0 to 85 degrees. The patient is considered homebound due to the significant effort required to leave the home, the need for an assistive device, and impaired balance, as evidenced by a Tinetti score of 12/28, indicating an increased risk for falls. The patient reports adherence to her prescribed medication regimen. Education was provided regarding medication compliance, including the purpose and potential side effects of medications. Blood glucose monitoring and the importance of maintaining adequate glycemic control were reviewed, and the patient verbalized understanding. Additional teaching was provided regarding pain management strategies, including when to report new or worsening pain. Wound care education was reinforced, including proper care of the surgical dressing and monitoring for signs and symptoms of infection. The patient participated in therapeutic exercises and tolerated 10 repetitions each of supine quadriceps sets, short arc quadriceps exercises, hip flexion, hip abduction, assisted straight leg raises, knee extension, and ankle pumps without complication. The patient was instructed to apply ice to the right knee several times daily for approximately 20 minutes to reduce swelling, to ambulate at least five times per day as tolerated to promote mobility and circulation, and to elevate the right lower extremity above heart level to assist with edema management. The patient demonstrated understanding of all education provided and agreed with the plan of care. Skilled nursing services are indicated for ongoing assessment, monitoring of the surgical site, medication and disease

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 04/10/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Patrick Narcisse
2391 Greenspring Dr
Timonium , MD 21093
PHONE: 410-847-3000 FAX: NPI: 1508397092

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 : 03/30/2026

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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management education, and reinforcement of safety and fall prevention strategies. The patient would also benefit from continued home therapy services to improve strength, increase range of motion, enhance functional mobility, and support a safe return to independence with activities of daily living.
 Date of Order 04/10/2026 Orders Physician Face-to-Face Date: 03/30/2026 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 Narcisse, Patrick

SN Careplans

SN WK1: 1 (04/10/26-04/11/26) ,WK2: 1 (04/12/26-04/18/26)

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

PROBLEMS IDENTIFIED ON ASSESSMENT: A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, meal preparation, M2102c - Med Admin, M2102f - Patient Supervision, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, swelling in legs/around eyes, limited range of motion, limited endurance, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, B1000 - Vision Deficit, #1 - Non-Observable Surgical Wound - Anterior Right Knee -

04/16/2026: #2 - Observable Surgical Wound - Anterior Right Knee

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Knee -, cough/deep breathing exercises, incentive spirometer, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange preparation of missing meals

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

SN Goals

PATIENT-STATED GOAL: Patient stated she wants to get back to herself

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
* 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
* 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 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

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	04/10/2026

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performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (04/10/26-04/11/26) ,WK2: 3 (04/12/26-04/18/26) ,WK3: 2 (04/19/26-04/25/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, Pain Effect on Sleep, GG0170O1 - 12 Steps, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, GG0170P1 - Picking Up Object, GG0170F1 - Toilet Transfer, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand

PROCEDURES: Home exercise program : Supine quad sets, short arc quads, hip flexion, straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, Stretching to right knee : Stretching right knee into flexion 5x hold 10 seconds. Initially 0-85, equipment training, gait training on uneven surfaces, 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 - 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, Car Transfer - 05. Setup or clean-up 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

PT Goals

PATIENT-STATED GOAL: Be able to get around with my cane again

GOALS
Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

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 - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Car Transfer - 05. Setup or clean-up 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 - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

Eating - 05. Setup or clean-up assistance

Upper Body Dressing - 06. Independent

12 Steps - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

Signature of Physician:

Date

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

Date
04/10/2026