Home Health Certification and Plan of Care

Order ID: 1150/18427

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
15189219	05/01/2026	From: 05/01/2026 To: 06/29/2026	24912	217058

6. Patient's Name and Address
Sharon Cheatham
1416 N Collington Ave,
Baltimore, MD 21213-
443-831-1226

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 08/18/1957 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	05/01/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.652	Presence of left artificial knee joint	05/01/26
M17.11	Unilateral primary osteoarthritis right knee	05/01/26
G40.909	Epilepsy unsp not intractable without status epilepticus	05/01/26
D89.89	Oth disrd involving the immune mechanism NEC	05/01/26
G43.709	Chronic migraine w/o aura not intractable w/o stat migr	05/01/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	05/01/26
J45.50	Severe persistent asthma uncomplicated	05/01/26
E04.1	Nontoxic single thyroid nodule	05/01/26
J30.9	Allergic rhinitis unspecified	05/01/26
E55.9	Vitamin D deficiency unspecified	05/01/26
F41.9	Anxiety disorder unspecified	05/01/26
K21.9	Gastro-esophageal reflux disease without esophagitis	05/01/26
E66.9	Obesity unspecified	05/01/26
Z68.30	Body mass index [BMI] 30.0-30.9 adult	05/01/26
Z79.82	Long term (current) use of aspirin	05/01/26
Z90.710	Acquired absence of both cervix and uterus	05/01/26
Z86.11	Personal history of tuberculosis	05/01/26
Z87.891	Personal history of nicotine dependence	05/01/26

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

ECOTRIN Delayed Release 81 mg / 1 Tablet by mouth 2 times a day
TYLENOL 500 mg / 1 Tablet by mouth every 6 hours as needed
KEPPRA 250 mg / 1 Tablet by mouth 2 times a day
SINGULAIR 10 mg / 1 Tablet by mouth daily
Calan Sr - Verapamil Hydrochloride 120 mg / 1 Tablet by mouth every morning with a meal
WIXELA INHUB Inhl Disk w/devi 500-50 mcg/dose / Inhale 1 puff by mouth twice a day (Controller inhaler)
ZYRTEC 10 mg / 1 Tablet by mouth daily
Zestril - Lisinopril 10 mg / 1 Tablet by mouth daily
COLACE 100 mg / 1-2 Capsule by mouth 2 times a day
Memantine Hydrochloride - Memantine Hydrochloride 5mg by mouth once a day Memory
Oxycodone Hydrochloride - Oxycodone Hydrochloride 5 mg 5mg by mouth every 4-6 hours Post surgical pain greater than 5
Motrin - Ibuprofen 600 mg 600mg by mouth every 6 hours Inflammation
ATROVENT 21 mcg (0.03 %) Nasl Spray / Use 2 sprays Each nostril twice a day
Albuterol Inhaler - Albuterol 90mcg inhalant as necessary Asthma
Cpap - Cpap 1 inhalant at bedtime Setting 1

14. DME and Supplies:
walker, cane

15. Safety Measures:
knee precautions, walker precautions, supervision at all times, standard precautions, None of the above, bathroom safety, fall precautions, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:
low sodium

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance

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

22.B.Discharge Plans
patient will be responsible for managing treatment

Homebound status: After undergoing 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: Start of care (SOC) visit completed, and all consents were reviewed and signed by the patient. The patient is a 68-year-old female status post left total knee replacement surgery performed by Dr. Narcisse. Past medical history is significant for osteoarthritis of the left knee, asthma, and obstructive sleep apnea requiring CPAP use during sleep. Patient is alert and oriented 4 and currently requires the use of a rolling walker with one-person assistance and supervision for safety and fall prevention following recent surgery, making leaving the home a considerable and taxing effort. Patient is considered homebound secondary to impaired mobility, postoperative weakness, pain, decreased endurance, and increased fall risk, as evidenced by a Tinetti balance and gait score of 14/28. Patient reported current pain level of 5/10 related to the recent surgical procedure. Education was provided regarding pain management, including proper use of prescribed oxycodone, anti-inflammatory medications, and application of ice therapy as directed to reduce pain and swelling. Patient denied any recent falls, dizziness, or lightheadedness. Surgical dressing remained intact during the visit, and patient was instructed on proper dressing care, including keeping the dressing clean, dry, and avoiding soaking or getting the area wet. No additional wounds or skin concerns were noted on assessment. Patient was informed that at the next skilled nursing visit, the postoperative dressing will be removed, the incision site assessed and measured, and wound photographs obtained per protocol. Patient was instructed to contact the surgeon immediately for any increase in pain, swelling, bruising, drainage, redness, or signs of infection. No abnormal bleeding was reported or observed. Patient reported last bowel movement occurred yesterday. Education was provided regarding bowel regimen management and use of stool softeners to prevent constipation associated with opioid pain medication use. Patient denied nausea, stating that postoperative nausea had resolved. Appetite was reported as good, and patient denied difficulty eating despite having partial upper dentures. Patient denied urinary discomfort and was instructed on maintaining adequate hydration to prevent dehydration and support postoperative recovery. Lung sounds were clear to auscultation bilaterally, with no abnormal respiratory findings noted during assessment. Patient demonstrated correct use of the incentive spirometer and verbalized understanding of the importance of pulmonary exercises and CPAP compliance for respiratory support and prevention of postoperative complications. Patient resides with her husband and granddaughter, who assist with caregiving needs in the home. Functional mobility assessment revealed that the patient ambulates approximately 30 feet on indoor surfaces using a rolling walker with supervision. Patient is able to negotiate 14 stairs using a handrail and cane with a step-to gait pattern under supervision. Bed mobility and transfers to bed, chair, and toilet are completed with supervision. Outside ambulation and car transfer skills were not assessed during this visit. Patient tolerated therapeutic exercises well, including 10 repetitions each of supine quadriceps sets, hip flexion exercises, short arc quadriceps exercises, straight leg raises, hip abduction exercises, seated knee extensions, and ankle pumps. Left knee range of motion was measured at 0 to 100 degrees. Skilled home health nursing and physical therapy services remain medically necessary to address postoperative pain, mobility deficits, strength, range of motion, gait training, fall prevention, safety

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 05/01/2026

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 : 04/10/2026

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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education, and progression toward independence with functional mobility and activities of daily living. Skilled nursing frequency planned as 1 visit weekly for 1 week, followed by an additional 1 visit weekly for 1 week as ordered.
 Date of Order 05/01/2026 Orders Physician Face-to-Face Date: 04/10/2026 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 Narcisse, Patrick

SN Careplans

SN WK1: 1 (05/01/26-05/02/26) ,WK2: 1 (05/03/26-05/09/26)

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: 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; 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 ; 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.

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.
Advance Directive:No advance directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, meal preparation, M2102f - Patient Supervision, M2020 - Oral Med Management, M1400 - Dyspnea, abnormal blood pressure, heartburn/indigestion, swelling of affected area, limited endurance, limited range of motion, Pain Effect on Sleep, B1000 - Vision Deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, balance deficit, pain radiating to arms/legs, #1 - Non-Observable Surgical Wound - Anterior Left Knee - , swell/redness surround. skin, red/tender pressure points

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee -, cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments: Husband and granddaughter educated on medications dressing care and ambulatory safety, physician-ordered wound care: 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., coordinate/arrange for adequate patient supervision, 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,

SN Goals

PATIENT-STATED GOAL: To recover for this surgery to get right knee joint replacement

GOALS
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
* 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 is adequately supervised

meal preparation is available to patient for all meals

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	05/01/2026

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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 is adequately supervised, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT WK1: 1 (05/01/26-05/02/26) ,WK2: 3 (05/03/26-05/09/26) ,WK3: 2 (05/10/26-05/16/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with ADLs, GG0170O1 - 12 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, GG0170G1 - Car Transfer, GG0170P1 - Picking Up Object, 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, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, #2 - Observable Surgical Wound - Anterior Left Knee -

PROCEDURES: physician-ordered wound care: #2 - Observable Surgical Wound - Anterior Left Knee -: Leave wound open to air, Stretching to left knee. Original ROM 0-100 degrees: 5x hold 10 seconds, physician-ordered wound care: Done by nursing, physician-ordered wound care: Leave open to air, wound vacuum: Patient does not have a wound vac, 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, 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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 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 - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: To be able to walk in the house with a cane

GOALS
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

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

12 Steps - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Shower/Bathe Self - 02. Substantial/maximal assistance

Eating - 06. Independent

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

Toileting Hygiene - 06. Independent

Upper Body Dressing - 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

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

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

Car Transfer - 05. Setup or clean-up assistance

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	05/01/2026