HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022150

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
8ED0JU1VE34	09/16/2026	09/16/2026 - 11/14/2026	29585	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Ronald Trusty 1401 N. Lakewood Ave Apt 216 BALTIMORE, MD 21213	Male	06/01/1949	443-401-1372
	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:

The patient is a 77-year-old male with a significant medical history of idiopathic gout of the right knee, pyogenic and staphylococcal arthritis of the right ankle and foot, bilateral hip osteoarthritis, CAD, hypertension, CHF, COPD, and acute renal failure. He was recently hospitalized due to significant right lower-extremity swelling and pain that impaired his ability to ambulate; fluid was drained from the affected leg, followed by a rehabilitation stay. The patient is alert and oriented 4, with mild residual swelling of the right leg and compression socks in place. Vital signs were within normal limits. He is currently prescribed three antihypertensive medications and was instructed to monitor his blood pressure prior to taking them; education on proper use of his home blood pressure monitor was provided, and his fiance demonstrated understanding. The patient ambulates slowly with a slight limp, using a cane for approximately 40 feet indoors with supervision and a cane when leaving the home. He is able to transfer to a recliner, chair, or toilet with supervision and sleeps in a recliner due to shortness of breath when lying supine. His Tinetti score is 16/28, indicating impaired balance and mobility and an increased risk for falls. He tolerated therapeutic exercises targeting the lower and upper extremities and would benefit from skilled home health PT to improve strength, balance, safety, and functional mobility toward greater independence. OT evaluation found the patient currently functioning at an independent level with basic self-care, functional transfers, and functional ambulation; therefore, no additional skilled OT services are warranted at this time.<o:p></o:p>

Date of Order<o:p></o:p>
09/16/2026<o:p></o:p>
Physician Face-to-Face Date:
09/09/2026<o:p></o:p>
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Staphylococcal arthritis right ankle and foot<o:p></o:p>

Physician Statement on Homebound Status:

Due to diagnosis of Staphylococcal arthritis right ankle and foot, 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

Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p> 1 - SOC - SN Notes: <o:p></o:p> PT Eval Notes:<o:p></o:p> OT Eval Notes:<o:p></o:p> Physician: Robinson, Sofia	

ICD-10 CM Principal Diagnosis: M00.071. Staphylococcal arthritis right ankle and foot

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
M10.061	Idiopathic gout right knee	ASPIRIN 0 Chewable 81 MG / 1 Tablet by mouth one time a day for blood thinner ATORVASTATIN 80 MG / 1 Tablet by mouth one time a day for Hyperlipidemia CARVEDILOL 6.25 mg 1 Tablet by mouth two times a day for Hypertension Cozaar - Losartan Potassium 50 mg Take 1 tablet by mouth once a day HTN Nifedipine - Nifedipine 30 mg Take 1 tablet by mouth once a day HTN Triamcinolone Acetonide - Triamcinolone Acetonide 0.1% ointment / Apply to bilateral leg topically as directed every 2 weeks on Mon, Fri for dermatitis Alternative with tacrolimus ointment with a week break in between Albuterol Sulfate - Albuterol Sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization by mouth every 4 hours as needed 1 application inhale orally via nebulizer for Wheezing; SOB Breo Ellipta - Fluticasone Furoate: Vilanterol Trifenatate 200-25 mcg/dose blister with device / Inhale 1 puff by mouth one time a day for COPD Hydroxyzine - Hydroxyzine Hydrochloride 25mg, take 1 tablet by mouth at bedtime As needed for itching TACROLIMUS 0.1% ointment / Apply to bilateral leg topically as directed every 2 weeks on Mon, Fri for dermatitis Alternate with triamcinolone cream with a week in between Sennosides - Senna 8.6 MG Tablet / Give 2 tablet by mouth every 12 hours as needed for CONSTIPATION sacubitril-valsartan 24-26 MG / 1 Tablet by mouth two times a day for Heart Failure for 30 Days Naloxone Hcl - Naloxone Hydrochloride - Nasal as needed Nasal Liquid. 1 spray in nostril as needed for suspected opioid overdose Use 1 spray in one nostril for suspected overdose. May repeat once in other nostril if no response in 3 minutes. Call 911. Lubriderm Topical Lotion (Emollient) - topical twice a day Apply to bilateral knee for dry skin for 30 Days FUROSEMIDE 40 MG / 1 Tablet by mouth one time a day for HTN DAPAGLIFLOZIN 5 MG / 1 Tablet by mouth once a day for diabetes ACETAMINOPHEN 500 MG Tablet / Give 2 tablet by mouth every 8 hours as needed for pain
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	
I11.0	Hypertensive heart disease with heart failure	
I50.22	Chronic systolic (congestive) heart failure	
J44.9	Chronic obstructive pulmonary disease unspecified	
I45.10	Unspecified right bundle-branch block	
L30.9	Dermatitis unspecified	
N17.9	Acute kidney failure unspecified	
F11.10	Opioid abuse uncomplicated	
Z79.84	Long term (current) use of oral hypoglycemic drugs	
Z79.82	Long term (current) use of aspirin	
Z79.51	Long term (current) use of inhaled steroids	

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	**Activities Permitted** No Restrictions
DME & Supplies nebulizer, cane	**Safety Measures** supervision at all times, medication safety, fall precautions, ambulates with device, standard precautions, , , activity supervision, bathroom safety
Nutrition low sodium	**Allergies** Contrast (Iohexol), Iodinated Contrast Media

Advance Directives	Caregiver Status
Durable power of attorney for health care/Medical power of attorney	1. Non-agency caregiver(s) currently provide assistance; 1. Non-agency caregiver(s) currently provide assistance
Rehabilitation Potential	**DISCHARGE PLAN:**
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.	SN, PT and OT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - SN

PT Eval

OT Eval

SN CAREPLAN

SN frequency WK1: 1 (09/16/26-09/19/26),WK2: 1 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26)

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; 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:Durable power of attorney for health care/Medical power of attorney

09/17/2026 Problems : M1400 - Dyspnea
M2020 - Oral Med Management
abnormal blood pressure
balance deficit
muscle weakness

PROCEDURES: cough/deep breathing exercises

SN NARRATIVE

The patient is a 77 year old male with a PMHx of idiopathic gout right knee, pyogenic arthritis, staphylococcal arthritis, right ankle and foot, chronic obstructive pulmonary disease, etc. He was hospitalized due to right leg swelling which was so painful that he couldn't walk, so he went to the ER. While there, fluid was drained off the leg and he was sent to the rehabilitation facility. He is alert and oriented X4, mild swelling was observed on the right leg. He has compression socks on. He is on 3 anti hypertensives and was advised to check his blood pressure before taking them. he had a blood pressure unit at home, so teaching on how to use it was provided. The patient's fiance demonstrated understanding. He ambulates slowly without an assistive device at home but uses a cane when he is leaving this house. Medication review was completed with the patient. His vitals were WNL.

SN GOALS

PATIENT-STATED GOAL: To get stronger and healthy.

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

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

OT CAREPLAN
OT frequency WK2: 1 (09/20/26-09/26/26)

09/21/2026 Problems : M1400 - Dyspnea

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, 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 NARRATIVE
77 year old male presenting to skilled OT services s/p hospitalization secondary to right leg swelling which was so painful that he couldn't walk PMH significant for idiopathic gout right knee, pyogenic arthritis, staphylococcal arthritis, right ankle and foot, chronic obstructive pulmonary disease. Patient previously resided with his fiance in a senior citizens apartment and was independent with basic self care, functional transfer and functional ambulation tasks. Patient currently presents functioning at independent level with basic self care, functional transfer and functional ambulation tasks. No additional OT services warranted at this time. Skilled OT evaluation only

OT GOALS
PATIENT-STATED GOAL: Evaluation only

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

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

PT CAREPLAN
PT frequency WK1: 1 (09/16/26-09/19/26),WK2: 1 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26),WK6: 1 (10/18/26-10/24/26),WK7: 1 (10/25/26-10/31/26),WK8: 1 (11/01/26-11/07/26)

09/21/2026 Problems : 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
GG0170P1 - Picking Up Object
GG0170D1 - Sit to Stand
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
GG0170F1 - Toilet Transfer

PROCEDURES: home exercise program: supine hip flexion, straight leg raise, hip abduction, standing knee flexion, hip abduction, hip extension, plantarflexion, squats, sitting knee extension, ankle pumps., gait training on uneven surfaces, 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 - 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, Picking Up Object - 05. Setup or clean-up assistance

PT NARRATIVE
Client is a 77year old with recent hospitalization and rehabilitation stay due to staphylococcal arthritis in right ankle and foot. History includes OA in bilateral hips, gout, CAD, HTN, CHF, COPD, ARF. Ambulates on indoor surface with cane 40 feet with supervision and slight limping gait. Transfers to recliner, chair or toilet with supervision. Sleeps in recliner due to shortness of breath when supine. Therapist did not assess steps, outside skills or car transfer. Client tolerated 10 reps of supine hip flexion, straight leg raise, hip abduction, standing knee flexion, hip abduction, hip extension, plantarflexion, squats, sitting knee extension, ankle pumps. Client is homebound due to significant effort to leave home and as evidenced by tinetti score of 16/28. Client would benefit from home therapy to increase strength and return to independence.

PT GOALS
PATIENT-STATED GOAL: To be able to get to the bus by myself and go to my appointments

GOALS
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

Sit to Stand - 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

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

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/16/2026

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: 09/09/2026

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 **Sophia Robinson**
1501 Division St
Baltimore, MD 21217
NPI 1831197722

Phone Number 4103838300

Fax Number 14107355154

Physician's Signature and Date Signed
X

Sophia Robinson, MD
09/09/2026: Date of physician last face-to-face