

Home Health Certification and Plan of Care				Order ID: 1150/17888	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
561297093		04/10/2026		From: 04/10/2026 To: 06/08/2026	
				4. Medical Record No.	
				21115	
				5. Provider No.	
				217058	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Ronald Armstrong 13 Misty Meadows Ct, ESSEX, MD 21221- 443-310-4078			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
04/10/1960			Male		
11. ICD			10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
Z47.1			Revatio - Sildenafil Citrate eq 20 mg base by mouth as necessary do not exceed one tablet in 24 hours		
Principal Diagnosis			as needed 1 hour prior to sexual activity, do not exceed one tablet in 24 hours		
Aftercare following joint replacement surgery			Pantoprazole - Pantoprazole Sodium 40 mg 1tablet by mouth after meal daily 30 to 60 minutes prior to a meal		
Date			Lipitor - Atorvastatin Calcium eq 40 mg base by mouth once a day daily for cholesterol and heart protection		
04/10/26			Lacosamide - Lacosamide 100 mg 1tablet by mouth twice a day		
13. ICD			Calcium Carbonate, Famotidine And Magnesium Hydroxide - Calcium Carbonate: Famotidine: Magnesium Hydroxide 1 tablet Oral daily		
Z96.652			Afaxin - Vitamin A Palmitate 1 tablet Oral daily		
Other Pertinent Diagnoses			Advair - Fluticasone Propionate: Salmeterol Xinafoate 1 spray Each nostril daily		
Z96.652			Adrucil - Fluorouracil to affected area(s) topical 2 times a day for 6 weeks.		
M17.11			Follow up in 3 months.		
Unilateral primary osteoarthritis right knee			Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5mg, 1 tablet by mouth every 4 hours As needed for pain		
J30.2			Aspirin 81Mg - Aspirin Take 1 tablet by mouth twice a day		
Other seasonal allergic rhinitis			Ibuprofen - Ibuprofen 600 mg Take 1 tablet by mouth every 6 hours Ax needed for pain		
G40.909			Colace - Docusate Sodium 100 mg , Take 1 tablet by mouth twice a day		
Epilepsy unsp not intractable without status epilepticus			Stool softener		
I70.0			Extra Strength Tylenol - Acetaminophen 500mg, 2 tablets by mouth every 8 hours As needed for pain		
Atherosclerosis of aorta					
M54.31					
Sciatica right side					
E78.5					
Hyperlipidemia unspecified					
K21.9					
Gastro-esophageal reflux disease without esophagitis					
E66.9					
Obesity unspecified					
Z68.30					
Body mass index [BMI] 30.0-30.9 adult					
Z86.018					
Personal history of other benign neoplasm					
Z96.1					
Presence of intraocular lens					
Z86.16					
Personal history of COVID-19					
Z87.891					
Personal history of nicotine dependence					
14. DME and Supplies:			15. Safety Measures:		
bath bench, walker, hospital bed, cane			no lifting, walker precautions, medication safety, ambulates with device, fall precautions, knee precautions, standard precautions		
16. Nutrition:			17. Allergies:		
regular			no known allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
Ambulation			Up As Tolerated		
19. Mental & COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Psychosocial Status: Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No					
20. Prognosis: fair					
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.			SN: patient will be responsible for managing treatment PT: another facility/provi		
Homebound status: After undergoing Left Total Knee Replacement surgery, 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: <p class="MsoNoSpacing">The patient is a 66-year-old male status post left knee replacement surgery with a past medical history significant for allergic rhinitis, left carpal tunnel syndrome, family history of coronary artery disease (CAD), and hyperlipidemia (HLD). He reports pain at a level of 8/10, managed with medication, ice, and elevation. He also reports a history of constipation, sometimes going 4-5 days without a bowel movement. He denies shortness of breath, nausea, vomiting, dizziness, or lightheadedness. The patient lives with his wife and ambulates using a walker. Medication reconciliation was completed. The surgical site is covered with an Aquacel dressing, scheduled for removal on postoperative day seven. Vital signs are within normal limits, and no respiratory distress is noted. On assessment, the patient presents with severe pain and moderate postoperative edema. Therapeutic exercises were performed in multiple positions: in supine (heel slides, straight leg raises, and lower extremity abduction/adduction), in sitting (heel slides and long arc quads), and in standing (marching and heel raises), each performed for 2 sets of 10 repetitions. The patient was also trained in the safe use of a walker and proper application of ice.</p><p class="MsoNoSpacing"><0:p> </o:p></p> <p class="MsoNoSpacing">Date of Order<0:p></o:p></p> <p class="MsoNoSpacing">04/10/2026 Physician Face-to-Face Date: 03/24/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left Total Knee Replacement surgery Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<0:p></o:p></p> <p class="MsoNoSpacing"> 1 - SOC - SN Notes: PT Eval Notes: <0:p></o:p></p> <p class="MsoNoSpacing">Physician: Narcisse, Patrick</p>					
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 04/10/2026					
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.		
Patrick Narcisse			F2F date : 03/24/2026		
2391 Greenspring Dr					
Timonium , MD 21093					
PHONE: 410-847-3000 FAX: NPI: 1508397092					
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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SN WK1: 1 (04/10/26-04/11/26) ,WK2: 1 (04/12/26-04/18/26)		PATIENT-STATED GOAL: To walk without pain		
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		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		
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance		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		
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion		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		
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.		patient/caregiver recalls * strategies to minimize fatigue and exhaustion including work simplification * energy conservation * lifestyle changes * diet * recalls related medication(s) purpose, schedule		
; 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		patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule		
PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, heartburn/indigestion, limited strength, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, irritation/discharge stoma site, swell/redness surround. skin, #1 - Non-Observable Surgical Wound - Anterior Left Knee - Left knee replacement surgery				
PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee - Left knee replacement surgery: Left knee surgical site: Remove Aquacel dressing on the 7th post-op day and LOTA. Cover with a dry gauze if drainage occurs., physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee - Left knee replacement surgery: Left knee surgical site: Remove Aquacel dressing on the 7th post-op day and LOTA. Cover with a dry gauze if drainage occurs., cough/deep breathing exercises, incentive spirometer				
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, * 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				
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, GG017001 - 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		PT Goals PATIENT-STATED GOAL: To walk straight without pain 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		
Signature of Physician:		Date PAGE 2 of 3		
Optional Name/Signature of Nurse/Therapist: Electronically Signed by Messick, Charles RN		Date 04/10/2026		

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PROCEDURES: therapeutic exercises: Heel slides, joint mobilization, slr, le abd/add, marching and heel raises --10x2 reps, 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 - 06. Independent, Sit to Stand - 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, 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, 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	Sit to Stand - 06. Independent Car Transfer - 06. Independent Picking Up Object - 05. Setup or clean-up assistance 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 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 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 4 Steps - 05. Setup or clean-up assistance 12 Steps - 05. Setup or clean-up assistance
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Signature of Physician:	Date
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