Home Health Certification and Plan of Care

Order ID: 1150/19677

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
79353446	06/11/2026	From: 06/11/2026 To: 08/09/2026	26272	217058

6. Patient's Name and Address

Mark Dunsmore
12060 Old Frederick Rd,
MARRIOTTSVILLE, MD 21104-
301-370-7335

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 05/23/1960 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	06/11/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	06/11/26
M10.9	Gout unspecified	06/11/26
I10.	Essential (primary) hypertension	06/11/26
I48.0	Paroxysmal atrial fibrillation	06/11/26
E78.5	Hyperlipidemia unspecified	06/11/26
I35.1	Nonrheumatic aortic (valve) insufficiency	06/11/26
E80.4	Gilbert syndrome	06/11/26
R47.01	Aphasia	06/11/26
F17.200	Nicotine dependence unspecified uncomplicated	06/11/26
Z79.01	Long term (current) use of anticoagulants	06/11/26
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	06/11/26

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

ELIQUIS 5 mg / 1 Tablet by mouth 2 times a day
Esidrix - Hydrochlorothiazide 25 mg tablet by mouth every morning
LIPITOR 10 mg / 1 Tablet by mouth daily For cholesterol and heart protection
NORVASC 5 mg / 1 Tablet by mouth daily
ROXICODONE 5 mg/tablet / Take 1-2 tablets by mouth every 4 hours as needed for pain (1-2 tabs as needed)
COLACE 100 mg / 1 Capsule by mouth 2 times a day
TYLENOL 500 mg / 1 Tablet by mouth as needed every 6 hours

14. DME and Supplies:

wound care supplies, walker, , cane, bath bench

15. Safety Measures:

walker precautions, transfer with assist, standard precautions, smoke detectors , medication safety, fall precautions, bleeding precautions, bathroom safety, aspiration precautions, ambulates with device, ambulates with assistance, activity supervision

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

sulfa drugs

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Transfer bed/Chair, 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: fair

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

family/caregiver will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: After undergoing Left total hip arthroplasty, 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:

The patient is a 66-year-old male admitted to home health services following a recent left total hip arthroplasty performed secondary to advanced osteoarthritis. At the time of assessment, the patient was postoperative day three. His past medical history is significant for osteoarthritis, chronic left hip pain, atrial fibrillation, hypertension, history of cerebrovascular accident, gout, and bilateral total knee arthroplasties. The patient was hospitalized overnight following surgery due to an episode of postoperative hypotension, which has since resolved without further complications. He currently resides with his son and daughter-in-law, both of whom provide assistance with daily care needs. The patient's daughter-in-law is a nurse, and family support is readily available within the home environment. Upon arrival for the skilled nursing visit, the patient was not at home and was observed returning from driving. The patient reported that he had left his walker at home and was noted exiting the vehicle while holding onto the car for support and ambulating with a cane. Skilled nursing education was immediately provided regarding the importance of adhering to postoperative and physician-directed restrictions, including refraining from driving until medically cleared by the surgeon. Additional reinforcement was provided regarding the consistent use of prescribed assistive devices to reduce fall risk and promote safe recovery. The patient verbalized understanding of all instructions provided. The patient reported ongoing left hip pain consistent with the recent surgical procedure but stated that he overall feels well. He denied fever, chills, or other signs and symptoms suggestive of infection. Vital signs were stable during the visit. Assessment of the surgical incision revealed the postoperative dressing to be intact with no evidence of excessive drainage, bleeding, or other visible complications. The patient reported uncertainty regarding the date of his postoperative follow-up appointments; however, he stated that his son manages all appointments and transportation arrangements to ensure compliance with follow-up care. A skilled physical therapy evaluation was completed and identified significant functional limitations related to the recent left total hip replacement. The patient presents with postoperative pain, left lower extremity weakness, impaired balance, and altered gait mechanics. These deficits have resulted in difficulty performing bed mobility, transfers, household ambulation, and stair negotiation safely and independently. The patient currently requires the use of an assistive device and caregiver support to safely complete mobility-related activities. Functional impairments place the patient at increased risk for falls, injury, delayed recovery, and decreased independence within the home environment. Skilled home health physical therapy is medically necessary to address lower extremity strengthening, balance deficits, gait abnormalities, transfer training, mobility limitations, and safety awareness. Treatment interventions will focus on restoring strength and functional mobility, improving gait mechanics, enhancing balance and endurance, promoting adherence to postoperative precautions, and maximizing independence with activities of daily living and mobility tasks. The overall goal is to facilitate a safe recovery, reduce fall risk, prevent postoperative complications, and support the patient's return to his prior level of function. Skilled nursing services will continue to provide postoperative monitoring, incision assessment, medication management, pain management education, reinforcement of physician-directed precautions, and patient/caregiver education. Ongoing interdisciplinary care will focus on promoting healing, preventing complications, ensuring compliance with the postoperative plan of care, and supporting the patient in achieving optimal functional outcomes within the home setting.
 Date of Order 06/11/2026 Orders Physician Face-to-Face Date: 06/03/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-pain control PT-eval & treat due to Left total hip arthroplasty 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:

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 06/11/2026

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 : 06/03/2026

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.

Home Health Certification and Plan of Care

Order ID: 1150/19677

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
79353446	06/11/2026	From: 06/11/2026 To: 08/09/2026	26272	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Mark Dunsmore 12060 Old Frederick Rd, MARRIOTTSVILLE, MD 21104- 301-370-7335	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

eval
 Physician Narcisse, Patrick

SN Careplans

SN WK1: 1 (06/11/26-06/13/26) ,WK2: 1 (06/14/26-06/20/26)

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 > 10

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: M2102d - Caregiver Performs Treatment, M2102c - Med Admin, M2102f - Patient Supervision, M2020 - Oral Med Management, abnormal blood pressure, M1400 - Dyspnea, abn cholesterol > 200 mg/dL, constipation, swelling of affected area, limited endurance, limited range of motion, limited strength, muscle weakness, poor muscle tone, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit, difficulty sleeping, obesity, discolored patches of skin, bruising/discoloration, red/tender pressure points

PROCEDURES: cough/deep breathing exercises, incentive spirometer, apply anti-embolitic stockings, train caregiver(s) to perform medical/rehabilitation treatments, physician-ordered wound care, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision

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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

SN Goals

PATIENT-STATED GOAL: To get back to my normal self

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

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

PT Careplans

PT Goals

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/11/2026

Home Health Certification and Plan of Care

Order ID: 1150/19677

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
79353446	06/11/2026	From: 06/11/2026 To: 08/09/2026	26272	217058

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Mark Dunsmore 12060 Old Frederick Rd, MARRIOTTSVILLE, MD 21104- 301-370-7335	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

PT WK1: 2 (06/11/26-06/13/26) ,WK2: 2 (06/14/26-06/20/26) ,WK3: 2 (06/21/26-06/27/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Interference with Therapy activities, 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, GG0170E1 - Chair to Bed to Chair, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, 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, GG0170D1 - Sit to Stand

PROCEDURES: B LE mm strengthening: 1, home exercise program: Ankle pumps, quad sets, glute sets, heel slides, partial squats, and seated/standing knee flexion and extension within tolerance. 10-15 reps ea. 1-2 set per day. Emphasis on improving right knee ROM, reducing stiffness, and promoting quadriceps activation. Patient instructed on proper technique, pacing, use of ice after exercises, and safe frequency throughout the day. Patient verbalized understanding and demonstrated good carryover., 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

PATIENT-STATED GOAL: to have a successful post surgical outcome

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

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

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

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	06/11/2026