HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022112

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
43303711100	09/15/2026	09/15/2026 - 11/13/2026	30212	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Hugh Pilgrim 2418 Hanson Road Apt 74 EDGEWOOD, MD 21040	Male	08/07/1976	410-812-1815
	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 50-year-old male with a past medical history significant for abnormal gait, bacteremia, bipolar disorder, hypothyroidism, type 2 diabetes mellitus, and a recent episode of right-sided facial weakness, facial droop, and slurred speech with acute CVA ruled out. According to his girlfriend/caregiver, Thelma, who was present during the assessment, they were visiting his son at Shock Trauma when she noticed the patient's facial drooping and slurred speech while they were in an elevator, prompting her to take him to the emergency department for evaluation. He was admitted for right-sided facial weakness, facial droop, slurred speech, and abnormal gait. CTA of the head and neck showed no evidence of an acute CVA. Brain MRI was not performed because, per Radiology, the patient has a fractured coronary stent that was considered unsafe for MRI; a repeat CT of the head showed a similar hypodensity in the right inferior frontal white matter. The patient was evaluated by physical therapy and subsequently discharged home. Upon assessment, he was alert and oriented 4, with intact skin, and denied shortness of breath, dizziness, or lightheadedness; he reported right foot pain and a recent episode of anxiety/panic for which he took clonazepam 0.5 mg. He is independent with ADLs and ambulates slowly without an assistive device. He has calluses on his feet and was evaluated by a podiatrist, who treated the calluses and instructed him to apply urea cream after bathing. Vital signs were within normal limits. Medication reconciliation was completed with the patient and his girlfriend. Education was provided regarding signs and symptoms of stroke, medication compliance, and fall prevention. The patient demonstrates potential to benefit from skilled physical therapy to establish a lower-extremity strengthening program, improve higher-level balance and gait, and address stair negotiation. The plan of care was also discussed with the patient's caregiver.<o:p></o:p>

Date of Order<o:p></o:p>
09/15/2026<o:p></o:p>
Physician Face-to-Face Date:

Physician Statement on Homebound Status:

Due to diagnosis of Type 2 diabetes mellitus with diabetic neuropathy, unspecified, 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

09/10/2026<o:p></o:p>
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat dx: Type 2 diabetes mellitus with diabetic neuropathy, unspecified<o:p></o:p>
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>
Physician: Tun, Zaw

ICD-10 CM Principal Diagnosis: E11.40. Type 2 diabetes mellitus with diabetic neuropathy unsp

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
R47.81	Slurred speech	ARIPIPRAZOLE 5 MG / 1 Tablet by mouth once a day Commonly known as: ABILIFY ZALEPLON 0 Take 5 MG capsule by mouth nightly Commonly known as: SONATA VENLAFAXINE Take 150 MG extended-release 24HR capsule by mouth once a day Commonly known as: EFFEXOR-XR TRAZODONE Take 50 MG tablet by mouth nightly PROPRANOLOL Take 10 MG tablet by mouth 2 times daily HOLD if SBP<110mmHg, Commonly known as: INDERAL METFORMIN Take 500 MG tablet extended release 24 HR by mouth every evening Commonly known as: GLUCOPHAGE XR LEVOTHYROXINE 0 Take 75 MCG tablet by mouth daily before breakfast Commonly known as: SYNTHROID INGREZZA 80 MG / 1 Capsule by mouth daily Generic drug: Valbenazine Tosylate GABAPENTIN Take 100 MG capsule by mouth 3 times daily Commonly known as: NEURONTIN fluticasone-salmeterol 250-50 MCG/ACT inhaler / Take 1 puff by inhalation every 12 hours Commonly known as: ADVAIR CLONAZEPAM Take 0.5 MG tablet by mouth every 12 hours as needed Commonly known as: KlonoPIN BUSPIRONE HCL Take 30 MG tablet by mouth 2 times daily Commonly known as: BUSPAR ATORVASTATIN Take 40 MG tablet by mouth nightly Commonly known as: LIPITOR ASPIRIN 0 Chewable 81 MG / 1 Tablet by mouth once a day
E03.9	Hypothyroidism unspecified	
F31.9	Bipolar disorder unspecified	
J43.9	Emphysema unspecified	
G47.33	Obstructive sleep apnea (adult) (pediatric)	
F41.9	Anxiety disorder unspecified	
E78.00	Pure hypercholesterolemia unspecified	
E05.00	Thyrotoxicosis w diffuse goiter w/o thyrotoxic crisis	
E55.9	Vitamin D deficiency unspecified	
F39.	Unspecified mood [affective] disorder	
F17.210	Nicotine dependence cigarettes uncomplicated	
F10.11	Alcohol abuse in remission	
Z79.84	Long term (current) use of oral hypoglycemic drugs	
Z79.82	Long term (current) use of aspirin	

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: Yes

Functional Limitations
Ambulation

Activities Permitted
Up As Tolerated, Exercises Prescribed,

DME & Supplies
diabetic supplies

Safety Measures
smoke detectors , emergency phone # clearly displayed, ambulates with assistance, hand rails, supervision at all times, transfer with assist, bleeding precautions, medication safety, fall precautions, diabetic precautions, standard precautions, bathroom safety, activity supervision

Nutrition
diabetic

Allergies
chantix, Bupropion, Latuda [Lurasidone]

Advance Directives	Caregiver Status
Durable power of attorney for health care/Medical power of attorney	2. Non-agency caregiver(s) need training/supportive services to provide assistance; 2. Non-agency caregiver(s) need training/supportive services to 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 and PT: family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - SN

PT Eval

SN CAREPLAN

SN frequency WK1: 1 (09/15/26-09/19/26),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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2

or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

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

09/16/2026 Problems : limited strength (MS)
limited endurance (MS)

SN NARRATIVE

The patient is a 50-year-old male with a PMHx of abnormal gait and right facial droop: Acute CVA ruled out. Bacteremia, Bipolar disorder, Hypothyroidism, Type 2 diabetes mellitus, etc. He is alert and oriented x4. According to his girlfriend /caregiver, Thelma, who was available during the assessment, they went to the shock trauma to see his son, while in the elevator, she noticed the facial drooping, and slurred speech, so she took him to the ER to get checked out. He was admitted with right sided facial weakness, right facial drop, slurred speech, and abnormal gait. patient had CTA of the head and neck, and no acute CVA. The patient cannot have MRI of the brain since per Radiology patient had broken coronary stent implanted and Radiology recommended not safe to do MRI of the brain- repeat CT head showed similar finding of hypodensity in the right inferior frontal white matter. He was evaluated by the physical therapist and then was sent home. His skin is intact, he denies pain, SOB, dizziness or lightheadedness, but reported that he had a case of panic anxiety, before the visit and he took a tablet. A 0.5mg of clonazepam to relieve the anxiety. He is independent with ADL'S, ambulates slowly without an assistive device but has calluses. He saw a podiatrist, who took care of the calluses and ordered him to apply urea cream to it after taking a bath. His vitals were WNL. Medication review was completed with the patient and his girlfriend. Teaching on the signs of CVA, medication compliance, and fall precautions were provided.

SN GOALS

PATIENT-STATED GOAL: To get better and stronger.

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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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

caregiver administers and/or packages medications appropriately

M1400 - Dyspnea M2020 - Oral Med Management abnormal blood pressure balance deficit muscle weakness red/tender pressure points abnormal BS < 70/140 > mg/dL D0160 - Depression M2102d - Caregiver Performs Treatment M2102f - Patient Supervision M1033 - Exhaustion M2102c - Med Admin PROCEDURES: cough/deep breathing exercises, glucose testing via monitor, teach/coordinate/arrange medication packaging and/or administration 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, 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, caregiver administers and/or packages medications appropriately	

PT CAREPLAN

PT frequency WK1: 1 (09/15/26-09/19/26),WK2: 1 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26)

09/17/2026 Problems : GG0170O1 - 12 Steps
GG0130F1 - Upper Body Dressing
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: Medication management : Review medication with pt and caregiver, home exercise program: Knee extension, standi g hip abduction, hamstring curls, hip flexion and extension, mini squats 2-310, work simplification/energy conservation, dynamic standing balance exercises: Work on high level balance exercises to improve hip ankle step strategies and improve reaction time, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PT NARRATIVE

The patient is a 50-year-old male with a PMHx of abnormal gait and right facial droop: Acute CVA ruled out. Bacteremia, Bipolar disorder, Hypothyroidism, Type 2 diabetes mellitus, etc. He is alert and oriented x4. According to his girlfriend /caregiver, Thelma, who was available during the assessment, they went to the shock trauma to see his son, while in the elevator, she noticed the facial drooping, and slurred speech, so she took him to the ER to get checked out. He was admitted with right sided facial weakness, right facial drop, slurred speech, and abnormal gait. patient had CTA of the head and neck, and no acute CVA. He was evaluated by the physical therapist and then was sent home. His skin is intact, he reports pain R foot, reported that he had a case of panic anxiety, He is independent with ADL'S, ambulates slowly without an assistive device. Medication review was completed with the patient and his girlfriend. Teaching on the signs of CVA, medication compliance, and fall precautions were provided. Pt has potential to benefit from skilled physical therapy to establish a le strengthening program, high level balance and gait training and stair negotiation. Talked with pts caregiver re plan of care as well.

PT GOALS

PATIENT-STATED GOAL: To improve my balance and walking, get my CD l license and start working again.;To improve my balance and walking, get my CDL license and start working again.

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/15/2026

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: 09/10/2026

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 **Zaw Tun**
7070 Samuel Morse Dr
Columbia, MD 21046
NPI 1346587060

Phone Number 800-777-7904

Fax Number

Physician's Signature and Date Signed

X

Zaw Tun, MD
09/10/2026: Date of physician last face-to-face

Pilgrim, Hugh | Cert Period 09/15/26 - 11/13/26