Home Health Certification and Plan of Care

Order ID: 1150/16373

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
44303582300	02/18/2026	From: 02/18/2026 To: 04/18/2026	22499	217058

6. Patient's Name and Address

Carl Stigler
4120 Oak Rd Apt 122,
HALETHORPE, MD 21227-
443-467-5344

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 07/03/1963 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	02/18/26

13. ICD	Other Pertinent Diagnoses	Date
M47.816	Spondylosis w/o myelopathy or radiculopathy lumbar region	02/18/26
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	02/18/26
I50.32	Chronic diastolic (congestive) heart failure	02/18/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	02/18/26
N18.30	Chronic kidney disease stage 3 unspecified	02/18/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	02/18/26
I25.2	Old myocardial infarction	02/18/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	02/18/26
I45.6	Pre-excitation syndrome	02/18/26
F31.9	Bipolar disorder unspecified	02/18/26
F41.0	Panic disorder [episodic paroxysmal anxiety]	02/18/26
E78.5	Hyperlipidemia unspecified	02/18/26
K50.90	Crohn's disease unspecified without complications	02/18/26
K21.9	Gastro-esophageal reflux disease without esophagitis	02/18/26
M51.369	Oth intvrt disc degen lum rgn w/o lum bck or lw extrm painOth intvrt disc degen lum rgn w/o lum bck or lw extrm pain	02/18/26
E66.9	Obesity unspecified	02/18/26
Z68.34	Body mass index [BMI] 34.0-34.9 adult	02/18/26
Z79.4	Long term (current) use of insulin	02/18/26
Z79.85	Lng trm (crnt) use injectable non-insulin antidiabetic drugs	02/18/26
Z79.02	Long term (current) use of antithrombotics/antiplatelets	02/18/26
Z79.82	Long term (current) use of aspirin	02/18/26

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

FISH OIL mouth daily
DOXEPIN HYDROCHLORIDE 10 mg / 1 Capsule by mouth three times a day before meals as needed for Other (Anxiety). Commonly known as: SINEquan
CLOPIDOGREL 75 mg / 1 Tablet by mouth once a day Commonly known as: PLAVIX
Aspirin 81Mg - Aspirin / 1 Tablet by mouth once a day
ESCITALOPRAM 20 mg / 1 Tablet by mouth once a day Commonly known as: LEXAPRO
Famotidine - Famotidine 20 mg / 1 Tablet by mouth once a day Commonly known as: PEPCID
Fenofibrate - Fenofibrate 48 mg / 1 Tablet by mouth once a day Commonly known as: TRICOR
GABAPENTIN 300 mg / 1 Capsule by mouth three times a day Take 2 capsules. Commonly known as: NEURONTIN
Isosorbide Mononitrate - Isosorbide Mononitrate 30 mg / 1 Tablet by mouth in the morning Commonly known as: IMDUR
JARDIANCE 25 mg / 1 Tablet by mouth once a day Generic drug: Empagliflozin
Metoprolol Succinate - Metoprolol Succinate 25 mg / 1 Tablet by mouth once a day Commonly known as: TOPROL XL
Rosuvastatin Calcium - Rosuvastatin Calcium 20 mg / 1 Tablet by mouth once a day Commonly known as: CRESTOR
Ranolazine - Ranolazine 500 mg / 1 Tablet by mouth twice a day Commonly known as: RANEXA
Vitamin B-12 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox - by mouth once a day
Vitamin B-6 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox - by mouth once a day
Vitamin D - Ergocalciferol 125 MCG (5000 UT) / 1 Capsule by mouth once a day Commonly known as: CHOLECALCIFEROL
Tresiba - Insulin Degludec 100 UNIT/ML solution / Inject 36 Units subcutaneous once a day Commonly known as: TRESIBA
Tirzepatide 12.5 MG/0.5ML Soaj solution auto injector Inject 12.5 mg subcutaneous once a week (Wednesday) Commonly known as: MOUNJARO

14. DME and Supplies:

hand held shower, diabetic supplies, bath bench, grab bars

15. Safety Measures:

diabetic precautions, , avoid temperature extremes, , ambulates with assistance, smoke detectors , , bathroom safety

16. Nutrition:

diabetic

17. Allergies:

cymbalta haldol lamotrigine lithium seroquel voltaren

18.A. Functional Limitations

Ambulation, Dyspnea With Minimal Exertion

18.B. Activities Permitted

Exercises Prescribed, Transfer bed/Chair, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 3. Often, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

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

patient will be responsible for managing treatment

Homebound status: Due to diagnosis of Type 2 Diabetes Mellitus With Diabetic Polyneuropathy, 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.

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Messick, Charles RN on 02/18/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Benjamin Gillingham
5100 Eastern Ave
, MD 21224
PHONE: 4107719220 FAX: 14107719301 NPI: 1922636224

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 : 02/06/2026

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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Carl Stigler 4120 Oak Rd Apt 122, HALETHORPE, MD 21227- 443-467-5344	HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239

Clinical Condition Requiring Homecare:

Physical Therapy Start of Care (SOC) admission was completed, and all required consents were obtained. The patient is a 63-year-old male who was admitted to UMH on 02/06/2026 for evaluation of chest pain and subjective bilateral lower extremity heaviness described as "my legs felt like they weighed a ton." He was hospitalized overnight and discharged home the following day. His past medical history is significant for Bipolar I disorder, chest pain with high risk for cardiac etiology, congestive heart failure, stage 3 chronic kidney disease (GFR 30-59 mL/min), diabetes mellitus, essential hypertension, adult failure to thrive, gastroesophageal reflux disease, bilateral leg weakness, near syncope, and obstructive sleep apnea. The patient recently moved into a senior apartment building and lives alone. He reports ambulating within the home without an assistive device; however, he estimates approximately six falls over the past two months, attributing these episodes to intermittent lightheadedness. He has limited local family support, with a brother residing out of state who <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> infrequently. The patient orders groceries online and manages most daily needs independently. Due to cardiovascular and respiratory comorbidities, he demonstrates limited endurance for community mobility, resulting in exhaustion and prolonged recovery after leaving the home, thereby increasing fall risk and rendering routine outings unsafe without assistance. Medication reconciliation, patient assessment, and home safety evaluation were completed. The patient handbook was reviewed, and a Physical Therapy plan of care (POC) was discussed and developed collaboratively with the patient, who verbalized agreement. Clinical assessment reveals decreased endurance, bilateral lower extremity weakness, impaired balance, unsteady gait, decreased functional mobility, difficulty with stair negotiation, impaired transfer ability, decreased safety awareness, chronic bilateral knee pain (currently well controlled with prescribed medications), and a significant history of falls. These deficits place the patient at high risk for further falls, functional decline, and loss of independence without skilled intervention. To safely exit the home, the patient requires assistance from another person and use of an assistive device. During the visit, the patient was instructed in edema management, including education on contributing factors and positional strategies such as elevating lower extremities above heart level during rest periods and the potential use of compression garments if recommended by his physician. The patient verbalized understanding. Fall prevention education was provided, including risk factors and home safety modifications to reduce fall risk. Transfer training was initiated with emphasis on proper hand and foot placement, forward weight shift during sit-to-stand, and reaching back for the chair prior to sitting. The patient required standby assistance (SBA) for safe transfers. Gait training was conducted on level surfaces using a walker; the patient required SBA with verbal cues for proper positioning within the walker, increased bilateral step height and length, and overall safety awareness. Tinetti and Timed Up and Go (TUG) gait assessments were performed to evaluate fall risk and functional mobility. The patient was strongly advised to use the walker at all times for ambulation. Education was provided on the importance of daily ambulation to improve circulation and prevent complications associated with inactivity. A progressive walking program was initiated, recommending short walks within the home every 1-2 hours (1-2 repetitions), with longer walks beginning at 3-5 minutes and gradually increasing as tolerated. The patient was instructed to apply ice to bilateral knees for 20 minutes with an appropriate skin barrier and to perform skin checks every 5 minutes during application. Pain management education included taking analgesics at the onset of pain, monitoring for side effects such as dizziness and constipation, and premedicating approximately one hour prior to therapy sessions to optimize participation. The patient was instructed to contact emergency services or his healthcare provider for chest pain, unrelieved pain, or shortness of breath. The patient demonstrated understanding via teach-back. The patient will receive home physical therapy services beginning 02/18/2026 with a planned frequency of 1 visit for 1 week, 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> per week for 3 weeks (Monday/Wednesday), followed by 1 visit per week for 5 weeks (Wednesday). The referring provider, Dr. Benjamin Gilligham, has been notified of the completed admission. The overall plan focuses on improving strength, balance, gait stability, transfer safety, stair negotiation, endurance, and safety awareness to reduce fall risk and restore the patient's highest possible level of independent function within the home environment. Without skilled physical therapy intervention, the patient remains at high risk for recurrent falls, hospitalization, and further functional decline.
 Date of Order 02/18/2026 Orders Physician Face-to-Face Date: 02/06/2026 Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat due to Type 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-12 CE-FMS-Diabetes">Diabetes</mh> Mellitus With Diabetic Polyneuropathy 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 - PT Notes: soc
 Physician Gilligham, Benjamin

SN Careplans	SN Goals

PT Careplans	PT Goals
PT WK1: 1 (02/18/26-02/21/26) ,WK2: 2 (02/22/26-02/28/26) ,WK3: 2 (03/01/26-03/07/26) ,WK4: 1 (03/08/26-03/09/26) PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 50 > 90, O2 saturation < 88 > 100, pain < 0 > 5 CAREGIVER: 4. Assistance needed, but no non-agency caregiver(s) available 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, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 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;	PATIENT-STATED GOAL: I want to be able to walk better and to stop falling GOALS Chair to Bed to Chair - 06. Independent Toilet Transfer - 06. Independent patient/caregiver recalls * prevention exacerbation of anxiety condition including coping patterns * improved concentration * strategies to reduce anxiety * identification of anxiety precipitants, conflicts, and threats * recalls related m 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 medicatio

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/18/2026

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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 Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: 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, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, GG0170F1 - Toilet Transfer, D0160 - Depression, M1720 - Anxiety, M2102c - Med Admin, M2020 - Oral Med Management, D0700 - Social Isolation, lightheadedness, dizziness/syncope, chest pain, M1400 - Dyspnea, M1033 - Exhaustion, limited endurance, Pain Interference with ADLs, Pain Effect on Sleep

PROCEDURES: cough/deep breathing exercises, home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention, coordinate/arrange long-term socialization activities

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 medicatio, * 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 relaxatio, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related m, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * 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, * strategies to increase socialization, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately, Sit to Stand - 06. Independent, Chair to Bed to Chair - 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

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 relaxatio

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) purpos

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

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

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

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	02/18/2026