Home Health Certification and Plan of Care

Order ID: 1195/185

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
101379377300	07/15/2026	From: 07/15/2026 To: 09/12/2026	815	239350

6. Patient's Name and Address
Josephine Kemp
920 W Sheldon St Apt 304,
Gaylord, MI 49735-
(989) 448-8091

7. Provider's Name, Address and Telephone Number
Evergreen Home Health
403 W Main Street Suite A1
Gaylord, MI 49735-1887
989-214-1114
1184225021

8. DOB 01/03/1940 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S72.142D	Displ intertroch fx l femur subs for clos fx w routn heal	07/15/26

13. ICD	Other Pertinent Diagnoses	Date
J44.1	Chronic obstructive pulmonary disease w (acute) exacerbation	07/15/26
K74.60	Unspecified cirrhosis of liver	07/15/26
K76.6	Portal hypertension	07/15/26
N18.32	Chronic kidney disease stage 3b	07/15/26
G25.81	Restless legs syndrome	07/15/26
I10.	Essential (primary) hypertension	07/15/26
F32.A	Depression unspecified	07/15/26
R33.9	Retention of urine unspecified	07/15/26

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

Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 200-62.5-25 MCG/ACT (Fluticasone-Umeclidinium-Vilanterol) 1 inhalation inhale orally one time a day for sob
POTASSIUM 1 tablet by mouth every 24 hours as needed for Give with Metolazine when administered
OXYCODONE tablet by mouth every 4 hours as needed for Moderate-Severe pain
OMEPRAZOLE 40 mg capsule by mouth one time a day for gerd
MULTIVITAMIN 1 tablet by mouth one time a day for Supplement for bone health and healing
METOLAZONE 2.5 mg tablet by mouth every 24 hours as needed for increased LE edema
MAGNESIUM 30 ml by mouth every 72 hours as needed for constipation
LOVASTATIN 20 mg tablet by mouth one time a day for hyperlipidemia
GABAPENTIN 100 mg capsule by mouth every 12 hours as needed for neuropathy
FUROSEMIDE 40 mg tablet by mouth one time a day for edema
DUTASTERIDE AND TAMSULOSIN HYDROCHLORIDE capsule by mouth one time a day for post-foley urinary retention
CYCLOBENZAPRINE tablet by mouth every 8 hours as needed for muscle spasms
CLONAZEPAM 0.5 mg tablet by mouth every 24 hours as needed for RLS
CIMETIDINE 300 mg tablet by mouth one time a day for duodenal ulcer
CALCIUM tablet by mouth every 12 hours as needed for Indigestion
ASPIRIN 1 tablet by mouth two times a day for prophylactic
AMITRIPTYLINE tablet by mouth one time a day for depression
Albuterol-Budesonide Inhalation Aerosol 90-80 MCG/ACT 2 puff inhale orally every 6 hours as needed for SOB
ACETAMINOPHEN tablet by mouth every 6 hours as needed for Pain
PROPRANOLOL 0 tablet by mouth two times a day for htn

14. DME and Supplies:
bath bench, walker

15. Safety Measures:
bathroom safety, anticoagulant precautions, fall precautions, medication safety, walker precautions, ambulates with device

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
antibiotics!Penicillins

18.A. Functional Limitations
Endurance, Hearing, Ambulation

18.B. Activities Permitted
Up As Tolerated, Walker

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: 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
family/caregiver will be responsible for managing treatment

Homebound status: Absences from the home require considerable and taxing effort and infrequent or short duration.

Clinical Condition Requiring Homecare: Josephine is an 86yr old female who is homebound with a DX- S72.142D- DISPLACED INTERTROCHANTERIC FRACTURE OF LEFT FEMUR, SUBSEQUENT ENCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING. Josephine has an unsteady gait, poor balance and will need Physical Therapy services and Occupational Therapy for ADL functioning, strengthening, endurance, balance and to promote home safety and education. Josephine will also need an RN for vital monitoring and education on catheter. Cena to assist with showers

SN Careplans

SN WK1: 1 (07/15/26-07/18/26) ,WK2: 1 (07/19/26-07/25/26) ,WK3: 1 (07/26/26-08/01/26) ,WK4: 1 (08/02/26-08/08/26) ,WK5: 1 (08/09/26-08/15/26) ,WK6: 1 (08/16/26-08/22/26) ,WK7: 1 (08/23/26-08/29/26) ,WK8: 1 (08/30/26-09/05/26) ,WK9: 1 (09/06/26-09/12/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 94 > 101.0, heart rate < 50 > 100, respiratory rate < 12 > 20, blood pressure systolic < 90 > 150, blood pressure diastolic < 60 > 100, O2 saturation < 90 > 100, pain < 0 > 7

CAREGIVER: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

STANDING ORDERS: Home Health Clinician to provide ongoing patient and caregiver education regarding prevention of skin breakdown and pressure injuries during the home health episode as

SN Goals

PATIENT-STATED GOAL: Pt states having control of pain and increased mobility.

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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by ABRAHAM, ALEXIS SN RN on 07/15/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
LACEY KANE
825 N. CENTER AVE
GAYLORD, MI 49735
PHONE: (989) 731-7870 FAX: (989) 731-7721 NPI: 1144568080

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 : 07/13/2026

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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clinically indicated.; Home Health Clinician to assess fall risk and provide ongoing patient and caregiver education regarding fall prevention and home safety measures throughout the home health episode as clinically indicated.; Home Health Clinician to assess, monitor, educate, and implement non-pharmacological pain management interventions as clinically indicated throughout the home health episode. Notify physician/authorized provider of uncontrolled pain, significant changes in pain status, or adverse medication effects.; Home Health Clinician to assess, monitor, and provide patient/caregiver education regarding mood status, signs and symptoms of depression, and coping strategies throughout the home health episode. Notify physician/authorized provider of significant mood changes, safety concerns, or worsening depressive symptoms.; Home Health Clinician to implement standard and transmission-based infection control precautions as indicated and provide ongoing patient/caregiver education regarding infection prevention throughout the home health episode. Notify physician/authorized provider of suspected or confirmed infection or clinical deterioration.; Home Health Clinician to assess, review, and reinforce patient/caregiver emergency preparedness plan throughout the home health episode, recertifications and resumptions of care.; Home Health Clinician to assess patient advance directive status and provide education regarding advance care planning throughout the home health episode. Assist with identification, completion, or updating of advance directive documents as appropriate and within scope of practice.
Advance Directive:Living will and advanced directive Durable power of attorney- Tracy 9893704526 and Mike 5034907031

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, urine retention, B1000 - Vision Deficit

PROCEDURES: Med Sets: Complete med set for pt., cough/deep breathing exercises, incentive spirometer, monitor intake & output, catheter change, care & irrigation: Catheter last changed on 14th, not to removed until f/u appt at providers office on 8/3., coordinate/arrange resources for vision-impaired

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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule

* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

PT Careplans	PT Goals
PT WK2: 1 (07/19/26-07/25/26) PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs	

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by ABRAHAM, ALEXIS SN RN	07/15/2026