

Home Health Certification and Plan of Care				Order ID: 1195/211	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
1042703159V167021		07/16/2026		From: 07/16/2026 To: 09/13/2026	
4. Medical Record No.		5. Provider No.		819	
239350					
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
Ronald Johnson 17790 Schmailer Rd, ATLANTA, MI 49709- (989)306-6341			Evergreen Home Health 403 W Main Street Suite A1 Gaylord, MI 49735-1887 989-214-1114 1184225021		
8. DOB			9. Sex		
06/04/1944			Male		
11. ICD		Principal Diagnosis		Date	
Z46.6		Encounter for fitting and adjustment of urinary device		07/16/26	
13. ICD		Other Pertinent Diagnoses		Date	
Z96.0		Presence of urogenital implants		07/16/26	
14. DME and Supplies:			15. Safety Measures:		
walker			medication safety, fall precautions, walker precautions		
16. Nutrition:			17. Allergies:		
Z. NO PHYSICIAN-ORDERED DIET			no known allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
Hearing			Up As Tolerated, Walker		
19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 2. On awakening or at night only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required, HISTORY OF DEPRESSION: No					
20. Prognosis: Good					
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.			family/caregiver will be responsible for managing treatment		
Homebound status: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home					
Clinical Condition Requiring Homecare: Skilled home health referral for monthly Foley catheter changes.					
SN Careplans			SN Goals		
SN WK1: 1 (07/16/26-07/18/26) ,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) ,WK10: 1 (09/13/26-09/13/26)			PATIENT-STATED GOAL: Pt will be safe in home environment and independent.		
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			GOALS patient/caregiver recalls * how to keep home safe for patient with dementia * coping strategies for the caregiver* recalls related medication(s) purpose, schedule		
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance			patient/caregiver recalls * management of mental health condition including joining a peer group * maintaining regular contact with mental health professional * avoiding known stressors * controlling impulses * recalls related medication(s) purpose, schedule		
HOSPITALIZATION RISKS: 4. Multiple emergency department visits (2 or more) in the past 6 months, 7. Currently taking 5 or more medications			patient/caregiver recalls * urinary catheter management including how to flush catheter * change and wash drainage bags * prevent infection including proper handwashing * positioning of catheter * recalls related medication(s) purpose, schedule		
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 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-Durable Power of Attorney wife Lisa Johnson			patient/caregiver recalls * prevention including increase fluid intake * increase Vitamin C intake to promote acidic bladder environment (cranberry juice) * perineal hygiene * recalls related medication(s) purpose, schedule		
23. Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT		
Electronically Signed by ABRAHAM, ALEXIS SN RN on 07/16/2026					
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.		
ROBYN YATES 1105 SIXTH ST TRAVERSE CITY, MI 49684-2345 PHONE: (989) 497-2500 FAX: 19893214118 NPI: 1518174101			F2F date :		
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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ADVANCE DIRECTIVE/Durable Power of Attorney, Will, Last Will and Testament PROBLEMS IDENTIFIED ON ASSESSMENT: M1700 - Cognition, M1745 - Behavioral Issues, M2020 - Oral Med Management, M1400 - Dyspnea, M1600 - UTI, M1610 - Urinary Catheter, urine retention, B0200 - Hearing Deficit PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, catheter change, care & irrigation, coordinate/arrange home modifications for hearing impaired, i.e. alarms TEACH PATIENT/CAREGIVER: * how to keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * urinary catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, related medication(s) purpose, schedule	
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by ABRAHAM, ALEXIS SN RN	07/16/2026