Home Health Certification and Plan of Care

Order ID: 1195/200

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
5CH7QD6YY44	07/16/2026	From: 07/16/2026 To: 09/13/2026	351	239350

6. Patient's Name and Address

John Butka
812 WEST ST,
GAYLORD, MI 497358302-
(989) 732-4082

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 05/19/1939 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
S82.841D	Displ bimalleol fx r low leg subs for clos fx w routn heal	07/16/26

13. ICD	Other Pertinent Diagnoses	Date
J44.9	Chronic obstructive pulmonary disease unspecified	07/16/26
I48.91	Unspecified atrial fibrillation	07/16/26
E87.6	Hypokalemia	07/16/26
J96.01	Acute respiratory failure with hypoxia	07/16/26
S06.5X0D	Traum subdr hem w/o loss of consciousness subs	07/16/26
S06.0X0D	Concussion without loss of consciousness subs encntr	07/16/26
S01.02XD	Laceration with foreign body of scalp subsequent encounter	07/16/26

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

TYLENOL mg= 2 Tab Oral TID, PRN
SENNA Tab Oral q12hr, PRN
PRESERVISION 1 Cap Oral qAM
POTASSIUM mEq= 1 Tab Oral qAM
PEG-3350, SODIUM CHLORIDE, SODIUM BICARBONATE, POTASSIUM CHLORIDE AND BISACODYL mg= 1 supp rectal q72hr, PRN
OXYCODONE mg= 1 Tab Oral q6hr, PRN
MILK OF MAGNESIA 2.4 gm= 30 mL Oral Daily, PRN
METOPROLOL mg= 1 Tab Oral Daily
MAALOX 10-20ml Oral q6hr, PRN
LOPERAMIDE HYDROCHLORIDE 2 mg mg= 1 Tab Oral q4hr, PRN
ISOSORBIDE DINITRATE 30 mg mg= 1 Tab Oral qAM
IBUPROFEN 200 mg mg= 2 Cap Oral q6hr, PRN
HYDROCORTISONE 1 Appl Top BID, PRN
HYDROCHLOROthiazide-triamterene 50 mg-75 mg oral tablet Tab Oral qAM
GUAIFENESIN mg= 10 mL Oral q4hr, PRN
FLEET ENEMA 1 each rectal Daily, PRN
acetaminophen-HYDROcodone 325 mg-5 mg oral tablet Tab Oral q6hr, PRN

14. DME and Supplies:

wheelchair, bath bench

15. Safety Measures:

fall precautions, transfer with assist, no stair use, anticoagulant precautions, bathroom safety, wheelchair precautions

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:

no known allergies

18.A. Functional Limitations

Hearing, Ambulation, Endurance, Bowel/Bladder Incontinence, Paralysis

18.B. Activities Permitted

Transfer bed/Chair, Wheelchair

19. Mental & Pyschosocial Status: COGNITION: 3. Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time., ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 2. Sometimes, 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: 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

another facility/provider 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: n/a

SN Careplans

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)

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: 1. Non-agency caregiver(s) currently 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, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

STANDING ORDERS: 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 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

SN Goals

PATIENT-STATED GOAL: Pt goal is to get out of wheelchair and be able to ambulate independently again with his walker and get his boot removed off his R leg.

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/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 medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by GRANDCHAMP, SAVANNAH SN RN on 07/16/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

GRETCHEN BURRUS
1320 M-32
EAST GAYLORD, MI 49735
PHONE: (989) 731-5092 FAX: (989) 705-8323 NPI: 1376057976

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 : 07/07/2026

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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advance directive documents as appropriate and within scope of practice.; 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.Pt resides at retirement home, 24 hour care. Staff provides assistance w/dressing, all ADL's, and transfers.; 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.Pt uses wheelchair, educated on importance of getting out of chair every 2-3 hours and relieving the pressure to prevent skin breakdown/pressure ulcers.; 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.Educated pt and staff on monitoring the pt mood and behaviors due to the pt being agitated, angry, and upset during visit due to wife having dementia.
Advance Directive:Pt is DNR, waiting on physician to sign, pt has already signed. Has medical durable power of Attorney- Stephen Butka (son)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M1745 - Behavioral Issues, D0160 - Depression, D0700 - Social Isolation, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Exhaustion, swelling in the arms/legs, M1610 - Urinary Incontinence, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, B0200 - Hearing Deficit, B1000 - Vision Deficit, swell/redness surround. skin, rough/scaly/cracked skin, discolored patches of skin

PROCEDURES: Monitor Edema: Monitor BLE edema and discoloration/wounds, cough/deep breathing exercises, incentive spirometer, bladder training, coordinate/arrange resources for vision-impaired, 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 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, * 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 incontinence management including bladder training Kegel exercises skin 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, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, * strategies to increase socialization, related medication(s) purpose, schedule

* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
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* using mechanical aids

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by GRANDCHAMP, SAVANNAH SN RN	07/16/2026