Home Health Certification and Plan of Care

Order ID: 1195/227

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6VX8DH2ND68	05/27/2026	From: 07/26/2026 To: 09/23/2026	691	239350

6. Patient's Name and Address
NORMAN PESONEN
4949 TARI LN,
LEWISTON, MI 49756-
(989) 786-5610

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 05/02/1935 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
G20.C	Parkinsonism unspecified	05/27/26

13. ICD	Other Pertinent Diagnoses	Date
R53.1	Weakness	05/27/26
R29.6	Repeated falls	05/27/26
I10.	Essential (primary) hypertension	05/27/26
J47.9	Bronchiectasis uncomplicated	05/27/26
N40.1	Benign prostatic hyperplasia with lower urinary tract symp	05/27/26

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

Breo Ellipta Inhalation Aerosol Powder Breath Activated 200-25 MCG/ACT 1 puff inhalant once a day
Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT not available inhalant not available Please verify
Amlodipine Besylate - Amlodipine Besylate 2.5 mg / 1 tablet by mouth once a day
Aspirin 81Mg - Aspirin 81 mg / 1 capsule by mouth once a day
Azelastine HCl Nasal Solution 137 MCG/SPRAY 2 sprays each nostril Nasal as necessary 2 sprays each nostril once a day as needed (PRN) for allergy
Spironolactone - Spironolactone 25 mg / 1 tablet by mouth once a day

14. DME and Supplies:
walker

15. Safety Measures:
transfer with assist, fall precautions, Universal/infection precautions, Proper use of assistive devices

16. Nutrition:
cardiac diet, ,

17. Allergies:
Prinivil, Proscar

18.A. Functional Limitations
Endurance, Ambulation, Hearing

18.B. Activities Permitted
Walker, Up As Tolerated, Exercises Prescribed

19. Mental & Pyschosocial Status: COGNITION: 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer, ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

20. Prognosis: good

22. A Rehabilitation Potential:
SELF-CARE: , MOBILITY:

22.B.Discharge Plans
patient will be responsible for managing treatment

Homebound status: Leaving home requires a considerable and taxing effort. Because of illness or injury, the person needs a wheelchair and assistance of another person in order to leave their place of residence.

Clinical Condition Requiring Homecare: Parkinsonism, unspecified

SN Careplans

SN WK1: 1 (07/26/26-08/01/26) ,WK2: 1 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26) ,WK6: 1 (08/30/26-09/05/26) ,WK7: 1 (09/06/26-09/12/26) ,WK8: 1 (09/13/26-09/19/26) ,WK9: 1 (09/20/26-09/23/26)

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: 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), 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 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:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, dependent edema, swelling in the arms/legs, coughing, limited strength, muscle weakness, limited endurance

PROCEDURES: train caregiver(s) to perform medical/rehabilitation treatments

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

SN Goals

PATIENT-STATED GOAL: Get stronger and prevent further falls

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

patient has access to rent/utility assistance considering inability to pay

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by STRICKLER, SYDNEY SN on 07/23/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
JENNIFER MCBRIDE
3040 BOURN ST
LEWISTON, MI 49756-8134
PHONE: (989) 786-4877 FAX: 19897316723 NPI: 1043767395

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 :

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.

Home Health Certification and Plan of Care

Order ID: 1195/227

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6VX8DH2ND68	05/27/2026	From: 07/26/2026 To: 09/23/2026	691	239350

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
NORMAN PESONEN 4949 TARI LN, LEWISTON, MI 49756- (989) 786-5610	Evergreen Home Health 403 W Main Street Suite A1 Gaylord, MI 49735-1887 989-214-1114 1184225021

including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient has access to rent/utility assistance considering inability to pay, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by STRICKLER, SYDNEY SN	07/23/2026