Home Health Certification and Plan of Care

Order ID: 1195/70

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
H69469471	05/21/2026	From: 05/21/2026 To: 07/19/2026	669	239350

6. Patient's Name and Address
TERRY MITCHELL
912 W 11TH ST,
MIO, MI 48647-
(989) 826-5879

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 12/06/1966 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
L98.416	Non-prs chr ulcer of buttock with bone invl w/o evd of necr	05/21/26

13. ICD	Other Pertinent Diagnoses	Date
T81.31XD	Disruption of external operation (surgical) wound NEC subs	05/21/26
L02.31	Cutaneous abscess of buttock	05/21/26
C20.	Malignant neoplasm of rectum	05/21/26
C21.0	Malignant neoplasm of anus unspecified	05/21/26
W88.8XXS	Exposure to other ionizing radiation sequela	05/21/26
I10.	Essential (primary) hypertension	05/21/26
E66.01	Morbid (severe) obesity due to excess calories	05/21/26
Z68.41	Body mass index [BMI] 40.0-44.9 adult	05/21/26

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

Amlodipine - Amlodipine Besylate 10 MG / 1 tablet by mouth once a day frequency: daily
CVS Acetaminophen Ex St Oral Tablet 500 MG 500 mg / 1 tablet by mouth every 6 hours PRN for pain
Losartan Potassium-HCTZ Oral Tablet 50-12.5 MG 1 tablet by mouth once a day frequency: daily

14. DME and Supplies:
None of the above

15. Safety Measures:
None of the above

16. Nutrition:
high protein

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation, Hearing

18.B. Activities Permitted
None of the above

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: 4. Constantly, SOCIAL ISOLATION: 1. Rarely, 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 Non-pressure chronic ulcer of buttock with bone involvement without evidence of necrosis, 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.

Clinical Condition Requiring Homecare:

The patient was admitted to home health services for skilled nursing assessment, wound care, and ongoing education. Upon arrival, the registered nurse entered the home through the front door per the patient's request and was greeted by the patient's mother. The patient resides with his mother and her significant other. Two dogs were present in the home during the visit. The patient was found resting in his bedroom, lying in a hospital bed with his legs hanging over the footboard. Admission documents were reviewed with the patient and signed. The patient reported attending the wound care clinic every other Monday and requested home health skilled nursing visits on the alternating Mondays and every Friday for continued wound management. Current wound care orders include cleansing the wounds with antibacterial soap and water, rinsing thoroughly, patting dry, and covering with folded 4x4 gauze secured with Hyperfix tape. A comprehensive head-to-toe assessment was completed, and vital signs were obtained and remained within normal limits. Medication reconciliation was performed. During the assessment, the registered nurse observed the patient's urostomy drainage tubing connected with Gorilla tape to a small gasoline can being used as a urine collection container, which was placed inside a wash basin. The interior of the urostomy tubing contained a significant amount of biofilm and sediment. When questioned regarding this setup, the patient stated that conventional urostomy drainage bags frequently leak or fall to the floor and reported using gasoline cans for urine collection since his urostomy surgery. The patient further stated that he replaces the gasoline can approximately every six months and is due to replace it soon. Skilled nursing education was provided regarding proper urostomy care, the use of appropriate medical drainage equipment, infection prevention, and the potential health risks associated with using a non-medical urine collection container. The patient verbalized understanding but will require continued reinforcement and additional education to promote safe ostomy management. Focused wound assessment revealed two chronic non-healing surgical wounds located on the left gluteal region. Each wound measured approximately 0.5 cm in diameter with significant depth of approximately 4.5 cm and 10 cm, respectively. Both wounds exhibited a large amount of foul-smelling purulent drainage. Assessment findings suggested tunneling between the wounds, as drainage was expressed from one wound when a cotton-tipped applicator was inserted into the other. The patient reported minimal sensation and pain in the affected area. Wound care was performed according to physician orders using appropriate sterile technique, and the patient tolerated the procedure without difficulty. Following wound care, the patient's incontinence brief was noted to be saturated with wound drainage and blood. The registered nurse informed the patient and offered to replace the soiled brief; however, the patient refused, stating he would change it later. Education was provided regarding the increased risk of infection, skin breakdown, moisture-associated skin damage, and delayed wound healing associated with prolonged exposure to drainage and blood. The importance of maintaining a clean and dry wound environment to promote healing was emphasized. Despite education, the patient continued to refuse changing the brief. The patient agreed with the established plan of care. A home health admission folder containing agency information and contact numbers was provided after the patient declined assistance with setting up the Spruce application on his smartphone. Additional education was reinforced regarding wound care, signs and symptoms of infection, pressure injury prevention, proper urostomy care, and the importance of adhering to the prescribed treatment plan and follow-up appointments. The patient denied any further questions or concerns at the conclusion of the visit and remained clinically stable with vital signs within normal limits.
 Date of Order 05/21/2026 Orders Physician Face-to-Face Date: Clinical Condition Requiring Home Care per Certifying Physician: SN Observation and Assessment Wound for Signs and Symptoms of infection due to Non-pressure chronic ulcer of buttock with bone involvement without evidence of necrosis 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 - SN Notes: - Referral packet requests home health nursing twice weekly for wound care. Physician order documents left gluteus wound care with cleansing, secondary dressing, and securing with paper tape, plus instructions to keep the dressing clean and dry and stay out of wheelchair. - Recent wound clinic documentation states the patient presents to the wound care center with an open non-healing surgical wound. The left gluteus wound is persistent, deep to bone, nearly 6 cm deep on 05/11/2026, with no redness or foul drainage documented at that visit. Patient reported a single-day fever the prior week with Tmax less than 100F lasting less than 24 hours. Prognosis for healing was documented as unlikely at that time, with oncology imaging pending and no current plan for surgical repair.
 Physician Henigan, Tamyra

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by STRICKLER, SYDNEY SN on 05/21/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
TAMYRA HENIGAN
1320 E. M-32
GAYLORD, MI 49735
PHONE: (989) 731-5092 FAX: 19897018325 NPI: 1043304967

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.

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SN Careplans

SN Visit frequency 2x per week

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: 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: D0160 - Depression, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, M1610 - Urinary Catheter, B0200 - Hearing Deficit, #1 - Observable Surgical Wound - Anterior Right Thigh - Left gluteus(distal)

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Right Thigh - Left gluteus(distal), cough/deep breathing exercises, incentive spirometer, physician-ordered wound care, wound vacuum, catheter change, care & irrigation, coordinate/arrange home modifications for hearing impaired, i.e. alarms

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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, * 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 hearing-impaired including installing special fire-detector/CO2 alarms, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

SN Goals

PATIENT-STATED GOAL: Heal wounds

GOALS
patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

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

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by STRICKLER, SYDNEY SN	05/21/2026