

Home Health Certification and Plan of Care				Order ID: 1195/269	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
2RW9TG7HT39		07/25/2026		From: 07/25/2026 To: 09/22/2026	
4. Medical Record No.				5. Provider No.	
466-1				239350	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Virginia Miller 13934 BLUE HAVEN DR NE, KALKASKA, MI 496469150- (231) 587-8923				Evergreen Home Health 403 W Main Street Suite A1 Gaylord, MI 49735-1887 989-214-1114 1184225021	
8. DOB 09/13/1932 9.Sex Female				10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
11. ICD		Principal Diagnosis		Date	
S81.802A		Unspecified open wound left lower leg initial encounter		07/25/26	
13. ICD		Other Pertinent Diagnoses		Date	
14. DME and Supplies: bath bench, 4 wheeled walker				15. Safety Measures: walker precautions, infectious material management, fall precautions, diabetic precautions, ambulates with device, ambulates with assistance, , transfer with assist, anticoagulant precautions, ,	
16. Nutrition: diabetic, , ,				17. Allergies: nitrofurantoin - nausea, Evista - Edema, Norco - Vomiting	
18.A. Functional Limitations Endurance, Bowel/Bladder Incontinence, Ambulation, , Hearing				18.B. Activities Permitted Up As Tolerated, Walker,	
19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No					
20. Prognosis: Fair					
22. A Rehabilitation Potential: SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.				22.B.Discharge Plans family/caregiver will be responsible for managing treatment	
Homebound status:					
Clinical Condition Requiring Homecare: wound care to lower leg					
SN Careplans SN WK1: 1 (07/28/26-08/03/26) 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), 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				SN Goals PATIENT-STATED GOAL: Heal wound to L lower 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 * urinary incontinence management including bladder training * Kegel exercises * skin care * recalls related medication(s) purpose, schedule	
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by STRICKLER, SYDNEY SN on 07/25/2026				25. Date HHA Received Signed POT	
24. Physician's Name and Address NATHAN SAILOR 419 S CORAL ST # B KALKASKA, MI 49646 PHONE: (231) 258-7500 FAX: 12312587786 NPI: 1194017160				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. PAGE 1 of 2	

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			1184225021		
updating of advance directive documents as appropriate and within scope of practice.					
Advance Directive:No Advance Directive					
PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0700 - Social Isolation, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, swelling in legs/around eyes, dependent edema, M1610 - Urinary Incontinence, muscle weakness, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, B0200 - Hearing Deficit, B1000 - Vision Deficit, swell/redness surround. skin					
PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care, bladder training, 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, * 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, * strategies to increase socialization, related medication(s) purpose, schedule					
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* diet					
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by STRICKLER, SYDNEY SN	07/25/2026