Home Health Certification and Plan of Care

Order ID: 1195/274

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
X3L911927365	07/22/2026	From: 07/22/2026 To: 09/19/2026	155-3	239350

6. Patient's Name and Address
Nancy Hall
12429 MEANDERLINE RD,
CHARLEVOIX, MI 497201072-
(864) 421-7378

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 12/04/1933 | **9.Sex** Female

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
Premarin - Estrogens, Conjugated 0.625 mg/gm .625 topical two times per week
Meclizine - Meclizine Hydrochloride 1 tab by mouth three times a day as needed
Colace - Docusate Sodium 100mg, by mouth as necessary

11. ICD	Principal Diagnosis	Date
I10.	Essential (primary) hypertension	07/22/26

13. ICD	Other Pertinent Diagnoses	Date
G46.4	Cerebellar stroke syndrome	07/22/26
R53.1	Weakness	07/22/26

14. DME and Supplies:
grab bars, bath bench, wheelchair, walker

15. Safety Measures:
ambulates with assistance, fall precautions, ambulates with device, supervision at all times, transfer with assist, walker precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
Nausea, Vomiting, Sneezing (Itching)

18.A. Functional Limitations
Ambulation, Bowel/Bladder Incontinence

18.B. Activities Permitted
Exercises Prescribed

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: 0. Never, 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:

SN Careplans

SN Goals

PT Careplans

PT WK1: 1 (07/22/26-07/25/26) ,WK2: 1 (07/26/26-08/01/26) ,WK3: 1 (08/02/26-08/08/26) ,WK4: 1 (08/09/26-08/15/26) ,WK5: 1 (08/16/26-08/22/26) ,WK6: 1 (08/23/26-08/29/26) ,WK7: 1 (08/30/26-09/05/26) ,WK8: 1 (09/06/26-09/12/26) ,WK9: 1 (09/13/26-09/19/26)

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

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:DPOA- Sue Jones

PT Goals

PATIENT-STATED GOAL: Reduce 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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

caregiver performs medical/rehabilitation treatments with adequate competence

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

1 - Step (curb) - 02. Substantial/maximal assistance

4 Steps - 02. Substantial/maximal assistance

Car Transfer - 05. Setup or clean-up assistance

Picking Up Object - 02. Substantial/maximal assistance

Walk 10 Feet - 02. Substantial/maximal assistance

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Walk 150 Feet - 02. Substantial/maximal assistance

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by HILL, KAITLIN PT PT on 07/22/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
CATHERINE WONSKI
223 N PARK ST
BOYNE CITY, MI 49712
PHONE: (231) 417-6010 FAX: 12314176005 NPI: 1386755726

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 : 07/20/2026

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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PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170M1 - 1 - Step (curb), GG0130A1 - Eating, GG0130A1 - Eating, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0130A1 - Eating, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170E1 - Chair to Bed to Chair, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0170F1 - Toilet Transfer, GG0130C1 - Toileting Hygiene, GG0170D1 - Sit to Stand, GG0170G1 - Car Transfer, M2020 - Oral Med Management, M2102d - Caregiver Performs Treatment, M1400 - Dyspnea, M1610 - Urinary Incontinence, limited strength, limited endurance, weak hand grips, daytime fatigue, balance deficit

PROCEDURES: train caregiver(s) to perform medical/rehabilitation treatments, home exercise program, equipment training, work simplification/energy conservation, transfers training

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, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, caregiver performs medical/rehabilitation treatments with adequate competence, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 1 - Step (curb) - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Car Transfer - 05. Setup or clean-up assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by HILL, KAITLIN PT PT	07/22/2026