Home Health Certification and Plan of Care

Order ID: 1195/307

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
H73261209	07/20/2026	From: 07/20/2026 To: 09/17/2026	830	239350

6. Patient's Name and Address
Sharon Dipzinski
180 KELSEY DR,
GAYLORD, MI 497357320-
(989) 448-8712

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 08/03/1962 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	07/20/26

13. ICD	Other Pertinent Diagnoses	Date
M17.11	Unilateral primary osteoarthritis right knee	07/20/26
Z96.651	Presence of right artificial knee joint	07/20/26
F33.1	Major depressive disorder recurrent moderate	07/20/26
F41.1	Generalized anxiety disorder	07/20/26
E78.2	Mixed hyperlipidemia	07/20/26
K21.9	Gastro-esophageal reflux disease without esophagitis	07/20/26
E66.09	Other obesity due to excess calories	07/20/26
G89.29	Other chronic pain	07/20/26

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

ACETAMINOPHEN 500 MG mgs= 2 Tab Oral q6hr
ALBUTEROL 90 mcg See Instructions
ASPIRIN 81 MG mg See Instructions
CITALOPRAM 20 MG mg= 1.5 Tab Oral Daily 3 refills
CYCLOBENZAPRINE 10 MG mg See Instructions
HYDROXYZINE 25 MG mg Oral PRN ANXIETY 30 refills
MELOXICAM 7.5 MG mg See Instructions
NYSTATIN unit See Instructions
OMEPRAZOLE 20 MG mg See Instructions
OXYCODONE 5 MG mg= 1 Tab Oral q6hr, PRN
TRAMADOL 50 MG mg= 1 Tab Oral Q6H
TRIAMCINOLONE See instructions, 11 refills
VITAMIN 1000 mcg= 1 Tab Oral Daily 3 refills
Rosuvastatin Calcium - Rosuvastatin Calcium 10 mg by mouth once a day

14. DME and Supplies:
walker, cane

15. Safety Measures:
ambulates with device, fall precautions, medication safety, walker precautions, knee precautions, anticoagulant precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
Codeine (Altered mental status), Adhesive (Hives), Aspirin (Shortness of breath)

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Independent at Home, Cane, Up As Tolerated, Walker

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: 0. Never, 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
another facility/provider will be responsible for managing treatment
patient 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: placement

SN Careplans

SN WK1: 1 (07/20/26-07/25/26)

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: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 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:Pt lives with dad. States unsure if she has advanced directive or living will, her daughter who was not present at SOC is in charge of everything.

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0160 - Depression, M2020 - Oral Med Management, Home Safety, M1033 - Exhaustion, M1400 - Dyspnea, Pain Effect on Sleep, Pain

SN Goals

PATIENT-STATED GOAL: Pt states increased strength and mobility in knee post surgery.

GOALS
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
* 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
* 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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by ABRAHAM, ALEXIS SN RN on 07/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
TABITHA PARDO
825 N CENTER AVE STE 140
GAYLORD, MI 49735-1592
PHONE: (989) 731-7870 FAX: 19897317837 NPI: 1548852130

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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Interference with ADLs, difficulty sleeping

PROCEDURES: cough/deep breathing exercises, physician-ordered wound care: Removal of ace wrap 3 days post surgery, bandage to remain in place until first post op visit with doc, monitor s/s of infection.

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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, insects/rodents not present in the patient's living environment

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

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

insects/rodents not present in the patient's living environment

PT Careplans

PT WK1: 2 (07/20/26-07/25/26) ,WK2: 2 (07/26/26-08/01/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170P1 - Picking Up Object, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0170P1 - Picking Up Object, GG0170P1 - Picking Up Object, GG0170F1 - Toilet Transfer, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand, limited endurance, limited strength

PROCEDURES: physician-ordered wound care, home exercise program: Instruct HEP with progression as tolerated, with independent daily compliance, equipment training, work simplification/energy conservation, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Shower/Bathe Self - 05. Setup or clean-up assistance, Patient will demonstrate improved R knee AROM to >+90 degrees flexion and 0 degrees extension

PT Goals

PATIENT-STATED GOAL: Complete in home post surgical rehab, improve ambulation

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Patient will demonstrate improved R knee AROM to >+90 degrees flexion and 0 degrees extension

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by ABRAHAM, ALEXIS SN RN	07/20/2026