Home Health Certification and Plan of Care

Order ID: 1195/388

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
943286043	07/30/2026	From: 07/30/2026 To: 09/27/2026	862	239350

6. Patient's Name and Address
Rosilee Toth
7725 M 32 E,
JOHANNESBURG, MI 49751-
(989) 858-3764

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 01/21/1950 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
		-

13. ICD	Other Pertinent Diagnoses	Date
J30.1	Allergic rhinitis due to pollen	-
F41.1	Generalized anxiety disorder	-
E78.2	Mixed hyperlipidemia	-
M81.0	Age-related osteoporosis w/o current pathological fracture	-
I73.89	Other specified peripheral vascular diseases	-
M65.331	Trigger finger right middle finger	-

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

PREDNISONE 20 MG tab(s) by mouth Every day Duration: 3 Days Pickup at WALGREENS DRUG STORE #10404
NORCO 7.5 MG tab(s) by mouth Every 4 hours as needed for Moderate-Severe Pain Chronic low back pain with sciatica Chronic back pain greater than 3 months duration Acute bilateral low back pain with bilateral sciatica Duration: 30 Days To be taken every 4 to 6 hours for moderate to severe pain, not to exceed 5 tablets/day
ALBUTEROL 2 inh inhalation Every 4 hours as needed for wheezing albuterol-ipratropium (albuterol-ipratropium 2.5 mg-0.5 mg /3 mL inhalation solution) 2.5 MG Milliliter nebulized inhalation 4 times a day as needed for Wheezing Pickup at WALGREENS DRUG STORE #10404
CARVEDILOL 3.125 MG tab(s) by mouth 2 times a day
fluticasone/umeclidinium/vilanterol (Trelegy Ellipta 100 mcg-62.5 mcg-25 mcg/ inh inhalation powder) 1 puff(s) inhaled Every day at the same time every day
FUROSEMIDE 20 MG tab(s) by mouth Every day as needed for edema
LOSARTAN POTASSIUM 100 MG tab(s) by mouth Every day
LYRICA 200 MG cap by mouth 2 times a day
ROSUVASTATIN CALCIUM 40 MG tab(s) by mouth Every day

14. DME and Supplies:
grab bars

15. Safety Measures:
medication safety, O2 precautions, fall precautions

16. Nutrition:
regular

17. Allergies:
codeine, Cymbalta, DULoxetine, morphine, NSAIDs, penicillin, pentazocine, Talw

18.A. Functional Limitations
Endurance

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

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

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: Symptoms identified support difficulty to leave home for medical services required.

Clinical Condition Requiring Homecare: - Home care referral ordered for RN and Physical Therapy following hospitalization for COPD with difficulty leaving home for required medical services. - Patient was hospitalized for worsening shortness of breath with acute hypoxia and COPD exacerbation/acute on chronic hypoxic respiratory failure. She was treated with oxygen, IV corticosteroids transitioned to oral prednisone, antibiotic therapy, nebulizer treatments, incentive spirometry, and Acapella therapy. She improved to room air by discharge and was instructed to follow up with primary care and pulmonology.

SN Careplans

SN WK1: 1 (07/30/26-08/01/26)

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

SN Goals

PATIENT-STATED GOAL: Lung sounds to be clear and regain strength from COPD exacerbation.

GOALS
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
* strategies to minimize fatigue and exhaustion including work simplification

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by ABRAHAM, ALEXIS SN RN on 07/30/2026

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 : 07/29/2026

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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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: M1720 - Anxiety, M2020 - Oral Med Management, Home Safety, M1033 - Exhaustion, M1400 - Dyspnea, wheezing, lung sounds not clear, constipation, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange for maintenance of clean/uncluttered living area

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, * 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, patient's living environment is clean/uncluttered

* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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

patient's living environment is clean/uncluttered

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by ABRAHAM, ALEXIS SN RN	07/30/2026