Home Health Certification and Plan of Care

Order ID: 1195/400

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
134897069	07/22/2026	From: 07/22/2026 To: 09/19/2026	846	239350

6. Patient's Name and Address
Rodney Morgan
4216 COUNTY RD 489,
ONAWAY, MI 49765-
(989)733-5647

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 03/21/1951 | **9.Sex** Male

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

ACUTECT 1 EA Oral Misc, Unscheduled
AMLODIPINE 5 mg, 1 tabs Oral Daily
ARICEPT 5 mg, 1 tabs Oral QHS
AUGMENTIN '200' 500 MG tabs Oral Daily
DEPAKOTE 250 mg, 2 cap Oral TID
HALOPERIDOL 0.5 mg, 0.1 mL IV Push Q4H, PRN
ONDANSETRON 4 mg, 2 mL IV Push Q8H, PRN
PANTOPRAZOLE 40 mg, 1 tabs Oral Daily
SERTRALINE 200 mg, 2 tabs Oral QHS
METOPROLOL 25 mg, 1 tabs Oral Daily
WELLBUTRIN 300 mg, 2 tabs Oral Daily

11. ICD	Principal Diagnosis	Date
G93.40	Encephalopathy unspecified	07/22/26

13. ICD	Other Pertinent Diagnoses	Date
G35.	Multiple sclerosis	07/22/26
R13.12	Dysphagia oropharyngeal phase	07/22/26
R26.89	Other abnormalities of gait and mobility	07/22/26
F41.9	Anxiety disorder unspecified	07/22/26
I47.19	Other supraventricular tachycardia	07/22/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	07/22/26
I71.40	Abdominal aortic aneurysm without rupture unspecified	07/22/26
I71.21	Aneurysm of the ascending aorta without rupture	07/22/26

14. DME and Supplies:
walker

15. Safety Measures:
walker precautions, fall precautions

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
No Known Medication Allergies

18.A. Functional Limitations
Ambulation!Hearing

18.B. Activities Permitted
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: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., 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
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: homebound

SN Careplans

SN WK1: 1 ,WK2: 1) ,WK3: 1, WK 4: 1. WK 5: 1, WK 6: 1 , WK:71 , WK 8:1, WK9:1, Wk 10: 1

OT x 2 visits

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:Do not resuscitate (DNR) orders

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M2020 - Oral Med Management, M1400 - Dyspnea, poor muscle tone, muscle weakness, B1000 - Vision Deficit, bruising/discoloration

SN Goals

PATIENT-STATED GOAL: regain independence

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
* 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
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by GRANDCHAMP, SAVANNAH SN RN on 07/22/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
DARCIE DOHNAL
14734 PARK AVENUE BLDG A CHARLEVOIX PRIMARY CARE
CHARLEVOIX, MI 49720-1927
PHONE: (231) 547-6554 FAX: 12313927332 NPI: 1487800959

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 : 07/15/2026

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.

Home Health Certification and Plan of Care

Order ID: 1195/400

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
134897069	07/22/2026	From: 07/22/2026 To: 09/19/2026	846	239350

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
Rodney Morgan 4216 COUNTY RD 489, ONAWAY, MI 49765- (989)733-5647	Evergreen Home Health 403 W Main Street Suite A1 Gaylord, MI 49735-1887 989-214-1114 1184225021

PROCEDURES: cough/deep breathing exercises, incentive spirometer, swallowing exercises, coordinate/arrange resources for vision-impaired

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 keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule

PT Careplans

PT WK2: 1 (07/26/26-08/01/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object

PROCEDURES: home exercise program, gait training/stair training, transfers training

PT Goals

OT Careplans

OT WK2: 1 (07/26/26-08/01/26) ,WK3: 1 (08/02/26-08/08/26) ,WK4: 1 (08/09/26-08/15/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130A1 - Eating, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene

PROCEDURES: equipment training, work simplification/energy conservation, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Toilet Transfer - 06. Independent, Picking Up Object - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 05. Setup or clean-up assistance, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: PT will verbalize understanding of falls recovery edu in 30 days;PT will verbalize understanding of adaptive equ for decreased hand grip;PT will verbalize understanding of adaptive low vision techniques in 30 days

GOALS
Toilet Transfer - 06. Independent

Picking Up Object - 04. Supervision or touching assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 05. Setup or clean-up assistance

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by GRANDCHAMP, SAVANNAH SN RN	07/22/2026