

Home Health Certification and Plan of Care					Order ID: 1195/530	
1. Patient s HI claim No.		2. Start Of Care Date	3. Certification Period		4. Medical Record No.	5. Provider No.
124324903		07/16/2026	From: 07/16/2026 To: 09/13/2026		822	239350
6. Patient's Name and Address Mary Lockhart 66 HALF N MOUNT TOM RD, MIO, MI 48647- (989) 346-0041				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 07/02/1950 9. Sex Female				10. Medications: Dose/Frequency/Route (N)ew (C)hanged There are no Medications for this Plan of Care		
11. ICD I63.9	Principal Diagnosis Cerebral infarction unspecified			Date 07/16/26		
13. ICD I10. J44.9 N39.0 K21.9 R26.81 R47.1	Other Pertinent Diagnoses Essential (primary) hypertension Chronic obstructive pulmonary disease unspecified Urinary tract infection site not specified Gastro-esophageal reflux disease without esophagitis Unsteadiness on feet Dysarthria and anarthria			Date 07/16/26 07/16/26 07/16/26 07/16/26 07/16/26 07/16/26		
14. DME and Supplies: nebulizer, grab bars				15. Safety Measures: medication safety, bathroom safety, standard precautions, bleeding precautions		
16. Nutrition: cardiac diet				17. Allergies: aspirin!codeine, Keflex		
18.A. Functional Limitations Endurance, Ambulation, Bowel/Bladder Incontinence				18.B. Activities Permitted Up As Tolerated		
19. Mental & Psychosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 1. Rarely, 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 patient will be responsible for managing treatment family/caregiver will be responsible for managing treatment		
Homebound status: Symptoms identified support difficulty to leave home for medical services required.						
Clinical Condition Requiring Homecare: CVA						
SN Careplans SN WK1: 1 (07/16/26-07/18/26) ,WK2: 1 (07/19/26-07/25/26) ,WK3: 1 (07/26/26-08/01/26) ,WK4: 1 (08/02/26-08/08/26) ,WK5: 1 (08/09/26-08/15/26) ,WK6: 1 (08/16/26-08/22/26) ,WK7: 1 (08/23/26-08/29/26) ,WK8: 1 (08/30/26-09/05/26) ,WK9: 1 (09/06/26-09/12/26) 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), 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 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 updating of advance directive documents as appropriate and within scope of practice. Advance Directive:No Advance Directive				SN Goals PATIENT-STATED GOAL: Become more independent again. GOALS patient/caregiver recalls * prevention including increase fluid intake * increase Vitamin C intake to promote acidic bladder environment (cranberry juice) * perineal hygiene * 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 keep home safe for patient with dementia * coping strategies for the caregiver* recalls related medication(s) purpose, schedule patient/caregiver recalls * strategies to increase caloric intake * recalls related medication(s) purpose, schedule patient/caregiver recalls * urinary incontinence management including bladder training * Keglel exercises * skin care * recalls related medication(s) purpose, schedule patient/caregiver recalls * strategies to minimize fatigue and exhaustion including work simplification * energy conservation * lifestyle changes * diet		
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by STRICKLER, SYDNEY SN on 07/16/2026					25. Date HHA Received Signed POT	
24. Physician's Name and Address HERNAN MALDONADO 4000 WELLNESS DR MIDLAND, MI 48670-2000 PHONE: (844) 832-1956 FAX: 19896335241 NPI: 1306043773				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. PAGE 1 of 2		

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PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M1700 - Cognition, M2020 - Oral Med Management, meal preparation, M2102d - Caregiver Performs Treatment, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, M1400 - Dyspnea, weak pulses in feet, heartburn/indigestion, M1600 - UTI, M1610 - Urinary Incontinence, muscle weakness, limited strength, limited endurance, weak hand grips 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 keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * strategies to increase caloric intake, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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, meal preparation is available to patient for all meals, caregiver performs medical/rehabilitation treatments with adequate competence		* recalls related medication(s) purpose, schedule meal preparation is available to patient for all meals caregiver performs medical/rehabilitation treatments with adequate competence		
PT Careplans PT WK3: 1 (07/26/26-08/01/26) ,WK4: 1 (08/02/26-08/08/26) ,WK5: 1 (08/09/26-08/15/26) ,WK6: 1 (08/16/26-08/22/26) PROCEDURES: equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Shower/Bathe Self - 06. Independent		PT Goals Chair to Bed to Chair - 06. Independent Toilet Transfer - 06. Independent Sit to Stand - 06. Independent Car Transfer - 06. Independent Walk 150 Feet - 06. Independent Walk 10 ft on Uneven Surface - 06. Independent 1 - Step (curb) - 06. Independent 4 Steps - 06. Independent 12 Steps - 06. Independent Picking Up Object - 06. Independent Shower/Bathe Self - 06. Independent		

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by STRICKLER, SYDNEY SN	07/16/2026