Home Health Certification and Plan of Care

Order ID: 1195/553

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
973395053	08/03/2026	From: 08/03/2026 To: 10/01/2026	864	239350

6. Patient's Name and Address

Gerald Omstead
863 4TH ST,
CHARLEVOIX, MI 497209724-
(269) 339-7243

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 07/10/1943 | **9.Sex** Male

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

ACETAMINOPHEN 500 MG Tab Oral TID
ELIQUIS 5 MG Tab Oral BID
HYDROCHLOROTHIAZIDE 12.5 MG Cap Oral Daily
TOPROL-XL 50 MG Tab Oral Daily
TRAMADOL 50 MG Tab Oral q6hr, PRN Moderate Pain

11. ICD	Principal Diagnosis	Date
Z47.1	Aftercare following joint replacement surgery	08/03/26

13. ICD	Other Pertinent Diagnoses	Date
Z96.642	Presence of left artificial hip joint	08/03/26
I48.20	Chronic atrial fibrillation unspecified	08/03/26
I10.	Essential (primary) hypertension	08/03/26
N40.0	Benign prostatic hyperplasia without lower urinry tract symp	08/03/26
F32.A	Depression unspecified	08/03/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	08/03/26
G47.00	Insomnia unspecified	08/03/26
M25.512	Pain in left shoulder	08/03/26

14. DME and Supplies:

walker, bath bench

15. Safety Measures:

fall precautions, ambulates with device, hip precautions, walker precautions

16. Nutrition:

regular

17. Allergies:

no known allergies

18.A. Functional Limitations

None of the above

18.B. Activities Permitted

Up As Tolerated, Exercises Prescribed, Walker

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:

Clinical Condition Requiring Homecare: Evaluate and treat. S/P L THA

SN Careplans

SN Goals

PT Careplans

PT WK1: 1 (08/03/26-08/09/26)

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.

PT Goals

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

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

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by HILL, KAITLIN PT PT on 08/03/2026

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 : 07/27/2026

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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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:Yes

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0130B1 - Oral Hygiene, GG0170P1 - Picking Up Object, 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, GG0170D1 - Sit to Stand, GG0130A1 - Eating, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0170F1 - Toilet Transfer, GG0130C1 - Toileting Hygiene, GG0170E1 - Chair to Bed to Chair, M2020 - Oral Med Management, M1400 - Dyspnea, abnormal blood pressure, muscle weakness, limited strength, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs

PROCEDURES: cough/deep breathing exercises, home exercise program, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: patient self-administers medications as prescribed, related medication(s) purpose, schedule, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 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, Don/Doff Footwear - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Don/Doff Footwear - 06. Independent

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by HILL, KAITLIN PT PT	08/03/2026