Home Health Certification and Plan of Care

Order ID: 1195/694

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1012175665V161625	05/27/2026	From: 07/26/2026 To: 09/23/2026	9359-1	239350

6. Patient's Name and Address
WILLIAM RUCK
5215 COUNTY ROAD 612 APT 18,
LEWISTON, MI 49756-
(231) 631-6885

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 12/20/1941 **9.Sex** Male

11. ICD	Principal Diagnosis	Date
S32.010D	Wedge comprsn fx first lum vert subs for fx w routn heal	05/27/26

13. ICD	Other Pertinent Diagnoses	Date
S22.080D	Wedge comprsn fx T11-T12 vertebra subs for fx w routn heal	05/27/26
G62.9	Polyneuropathy unspecified	05/27/26
M81.0	Age-related osteoporosis w/o current pathological fracture	05/27/26
K26.4	Chronic or unspecified duodenal ulcer with hemorrhage	05/27/26
D51.9	Vitamin B12 deficiency anemia unspecified	05/27/26
M17.0	Bilateral primary osteoarthritis of knee	05/27/26
F41.9	Anxiety disorder unspecified	05/27/26
I10.	Essential (primary) hypertension	05/27/26
I35.0	Nonrheumatic aortic (valve) stenosis	05/27/26
Z87.81	Personal history of (healed) traumatic fracture	05/27/26
F10.90	Alcohol use unspecified uncomplicated	05/27/26
M51.360	Other intvrt disc degen	05/27/26

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

ACETAMINOPHEN 325 MG tablet by mouth three times a day for Pain Do NOT exceed 3000 mg of acetaminophen in 24-hour period from all sources.
ALENDRONATE SODIUM 70 MG tablet by mouth one time a day every week for AGGREVATED OSTEOPOROSIS (M81.0)
Calcium-Vitamin D Oral Tablet 600-400 IU-MCG 1 tablet by mouth one time a day for AGGREVATED OSTEOPOROSIS (M81.0)
CYANOCOBALAMIN 1 tablet 1000 MCG by mouth one time a day for VITAMIN B12 DEFICIENCY ANEMIA, UNSPECIFIED (D51.9)
SENOKOT 10 MG suppository rectally every 72 hours as needed for If not Bowel Movement in 72 hours.
ESCITALOPRAM 20 MG tablet by mouth one time a day for ANXIETY DISORDER, UNSPECIFIED (F41.9).
FAMOTIDINE 20 MG tablet by mouth one time a day for CHRONIC OR UNSPECIFIED DUODENAL ULCER WITH HEMORRHAGE (K26.4).
FLUTICASONE 50 MCG/ACT in each nostril one time a day for Seasonal allergies.
GABAPENTIN 400 MG MG three times a day for POLYNEUROPATHY, UNSPECIFIED (G62.9)
MAGNESIUM 400 MG ml by mouth every 8 hours as needed for if no Bowel Movement in 48 hours.
Nexium 20 MG MG by mouth one time a day for CHRONIC DUODENAL ULCER (K26.4)
CALCIUM 1 Wafer(s) po d
CVS Acetaminophen Ex St Oral Tablet 500 MG 500 MG Tab(s) po bid
CVS Fluticasone Propionate Nasal Suspension 50 MCG/ACT 2 sprays inh d
CVS Magnesium Oxide Oral Tablet 250 MG 250 MG Tab(s) po d
DICLOFENAC 2 gm tid td PRN inflammation
ETHMOZINE 10 MG Tab(s) po bid
LISINOPRIL 10 MG Tab(s) po d
PANTOPRAZOLE 40 MG Tab(s) po d

14. DME and Supplies:
bath bench, grab bars, walker,

15. Safety Measures:
fall precautions, ambulates with device, walker precautions, , bathroom safety

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
Doxycycline, CeleBREX, Zocor

18.A. Functional Limitations
Ambulation, Endurance, Hearing

18.B. Activities Permitted
Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: , MOBILITY:

22.B.Discharge Plans
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: patient fell backward at home, struck his head, and was admitted with intractable pain due to L1 vertebral fracture with chronic T12 compression fracture noted on imaging

SN Careplans

SN WK1: 1 (07/26/26-08/01/26) ,WK2: 1 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26) ,WK4: 1 (08/16/26-08/22/26) ,WK5: 1 (08/23/26-08/29/26) ,WK6: 1 (08/30/26-09/05/26) ,WK7: 1 (09/06/26-09/12/26) ,WK8: 1 (09/13/26-09/19/26) ,WK9: 1 (09/20/26-09/23/26)

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: 1. History of falls (2 or more falls- or any fall with an injury- in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 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

SN Goals

PATIENT-STATED GOAL: decrease lightheadedness and have better balance/mobility

GOALS
patient/caregiver recalls
* how to control alcohol withdrawal symptoms
* how to get support
* overcome cravings
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase socialization
* 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

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

25. Date HHA Received Signed POT

24. Physician's Name and Address
ROBYN YATES
1105 SIXTH ST
TRAVERSE CITY, MI 49684-2345
PHONE: (989) 497-2500 FAX: 19893214118 NPI: 1518174101

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 : 03/13/2026

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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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

PROBLEMS IDENTIFIED ON ASSESSMENT: lightheadedness, diarrhea, limited strength, limited range of motion, limited endurance, involuntary movement of extremity, balance deficit, loss of appetite

PROCEDURES: cough/deep breathing exercises, incentive spirometer, dialogue & listening: exploring life, values, fears, and hopes: Related to alcohol use.

TEACH PATIENT/CAREGIVER: * how to take the patient's blood pressure record the reading, 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, * how to control alcohol withdrawal symptoms how to get support overcome cravings, related medication(s) purpose, schedule, * how to optimize joint mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety pain control, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule

patient/caregiver recalls
* how to optimize joint mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* pain control
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by STRICKLER, SYDNEY SN RN	07/22/2026