Home Health Certification and Plan of Care

Order ID: 1195/628

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6M89A05AN56	05/18/2026	From: 07/17/2026 To: 09/14/2026	595	239350

6. Patient's Name and Address
KRISTINE BARNES
1021 S STATE AVE,
ALPENA, MI 49707-
(989) 657-1153

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 05/27/1952 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
I50.33	Acute on chronic diastolic (congestive) heart failure	05/18/26

13. ICD	Other Pertinent Diagnoses	Date
D50.0	Iron deficiency anemia secondary to blood loss (chronic)	05/18/26
K92.2	Gastrointestinal hemorrhage unspecified	05/18/26
K31.819	Angiodysplasia of stomach and duodenum without bleeding	05/18/26
K76.6	Portal hypertension	05/18/26
K74.60	Unspecified cirrhosis of liver	05/18/26
J96.11	Chronic respiratory failure with hypoxia	05/18/26
J84.9	Interstitial pulmonary disease unspecified	05/18/26
E11.9	Type 2 diabetes mellitus without complications	05/18/26

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

Folic Acid - Folic Acid 1 mg by mouth once a day True Folic Acid Oral Tablet 1 MG1 Tab (s) d
Vitamin D - Ergocalciferol 25 MCG (1000 UT) by mouth once a day Vitamin D (Cholecalciferol) Oral Tablet 25 MCG (1000 UT)1 Tab (s)
Sennosides - Senna 8.8 MG/5ML by mouth as necessary Sennosides Oral Syrup 8.8 MG/5ML
BID PRN CONST
POTASSIUM 20 MEQ by mouth twice a day Potassium Chloride ER Oral Tablet Extended Release 20 MEQ 1 Tab (s) bid
Mycophenolate Mofetil - Mycophenolate Mofetil 360 MG by mouth twice a day Mycophenolate Sodium Oral Tablet Delayed Release 360 MG 2 Tab (s) BID
Miconazole 3 - Miconazole Nitrate 2% topical twice a day Miconazole External Powder 2 %1 appl bid
Lidocaine Patch - Lidocaine 5% (140 MG) topical once a day Lidocaine External Patch 5% (140 MG)1 Patch(es) q 24 h
Levothyroxine Sodium - Levothyroxine Sodium 125 MCG by mouth once a day Levothyroxine Sodium Oral Tablet 125 MCG1 Tab (s) d
Acetaminophen - Acetaminophen 500 MG by mouth every 6 hours MM Acetaminophen Ex Str Oral Tablet 500 MG1 Tab (s) q 6 h
Zinc Sulfate - Zinc Sulfate 50 mg /1 tab by mouth once a day Zinc Sulfate Oral Capsule 50 MG 1 Cap(s) d
Pantoprazole - Pantoprazole Sodium 40 MG/ 1 Tab by mouth in the morning Pantoprazole Sodium Oral Tablet Delayed Release 40 MG1 Tab (s) qam
Multivitamins - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1 tablet by mouth once a day
Bumetanide - Bumetanide 1 MG by mouth twice a day
Carvedilol - Carvedilol 3.125 mg by mouth twice a day
Cocoa Butter Skin External Cream 1 application topical once a day
CYANOCOBALAMIN 500 MCG by mouth twice a day Cyanocobalamin Oral tablets 500 MCG. Take 2 tablets daily
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 500 MCG by mouth once a day
CALCIUM CARBONATE ORAL TABLET 1250 (500 CA) MG / 1 Tablet by mouth once a day
Melatonin - Melatonin 3 MG / 1 Tablet by mouth at bedtime PRN SLEEP
Ondansetron Hydrochloride - Ondansetron Hydrochloride 4 MG / 1 Tablet by mouth every 8 hours PRN NAUS/VOM

14. DME and Supplies:
walker

15. Safety Measures:
walker precautions, anticoagulant precautions, ambulates with device

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
Atorvastatin, Cat and Dog Dander, House Dust, Mold

18.A. Functional Limitations
Ambulation, Bowel/Bladder Incontinence, Hearing

18.B. Activities Permitted
No Restrictions

19. Mental & Pyschosocial Status: COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: 2. On awakening or at night only, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

20. Prognosis: good

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

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: Skilled Nursing to Assess and Eval resp. assessment, cardiac assessment, vitals due to Acute on chronic diastolic (congestive) heart failure

SN Careplans

SN WK1: 1 (07/17/26-07/18/26) ,WK3: 1 (07/26/26-08/01/26) ,WK4: 1 (08/02/26-08/08/26) ,WK5: 1 (08/09/26-08/15/26) ,WK7: 1 (08/23/26-08/29/26) ,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: 4. Multiple emergency department visits (2 or more) in the past 6 months

SN Goals

PATIENT-STATED GOAL: Get stronger

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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by GRANDCHAMP, SAVANNAH SN RN on 07/15/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
RONG LAWSON
ALPENA MEDICAL ARTS, PC 211 LONG RAPIDS ROAD
ALPENA, MI 49707
PHONE: (989) 358-4251 FAX: 19893548600 NPI: 1215116025

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 :

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: 1195/628

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
6M89A05AN56	05/18/2026	From: 07/17/2026 To: 09/14/2026	595	239350

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
KRISTINE BARNES 1021 S STATE AVE, ALPENA, MI 49707- (989) 657-1153	Evergreen Home Health 403 W Main Street Suite A1 Gaylord, MI 49735-1887 989-214-1114 1184225021

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

PROBLEMS IDENTIFIED ON ASSESSMENT: dependent edema (CR), swelling in legs/around eyes (CR), swelling in the arms/legs (CR), wheezing (CR), abnormal BS < 70/140 > mg/dL (EM), pain/discomfort during sex, foul-smelling urine, frequent urination, cloudy urine, limited strength (MS), B1000 - Vision Deficit

PROCEDURES: CHF education : CHF education, daily weight, etc.), cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, 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, * urinary incontinence management including bladder training Kegel exercises skin 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

* urinary incontinence management including bladder training
* Kegel exercises
* skin 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

PT Careplans

PT 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)

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170M1 - 1 - Step (curb), muscle weakness

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

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PT Goals

PATIENT-STATED GOAL: get better

GOALS
Toilet Transfer - 06. Independent

Shower/Bathe Self - 05. Setup or clean-up assistance

Picking Up Object - 04. Supervision or touching assistance

Upper Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Lower Body Dressing - 06. Independent

Toileting Hygiene - 06. Independent

Oral Hygiene - 06. Independent

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

Sit to Stand - 05. Setup or clean-up assistance

12 Steps - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 10 Feet - 04. Supervision or touching assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by GRANDCHAMP, SAVANNAH SN RN	07/15/2026