

Home Health Certification and Plan of Care							Order ID: 1195/776		
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period		4. Medical Record No.		5. Provider No.	
X3LM68428909		08/11/2026		From: 08/11/2026 To: 10/09/2026		895		239350	
6. Patient's Name and Address Michael Wahl 10550 E AU SABLE RD, SAINT HELEN, MI 48656-9330 (989) 808-2127					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 08/11/1949 9.Sex Male					10. Medications: Dose/Frequency/Route (N)ew (C)hanged ONDANSETRON 8 MG mg mouth every six hours as needed for nausea. PANTOPRAZOLE 40 MG mg mouth once daily, 30 min prior to meal. PRAVASTATIN 20 MG mg mouth every morning. RAMIPRIL 2.5 MG mg mouth at bedtime.				
11. ICD K31.1		Principal Diagnosis Adult hypertrophic pyloric stenosis			Date 08/11/26		15. Safety Measures: medication safety, fall precautions, standard precautions		
13. ICD K86.89		Other Pertinent Diagnoses Other specified diseases of pancreas			Date 08/11/26				
E87.1		Hypo-osmolality and hyponatremia			08/11/26				
R63.4		Abnormal weight loss			08/11/26				
E44.1		Mild protein-calorie malnutrition			08/11/26				
E83.42		Hypomagnesemia			08/11/26				
D64.9		Anemia unspecified			08/11/26				
I10.		Essential (primary) hypertension			08/11/26				
E78.5		Hyperlipidemia unspecified			08/11/26		17. Allergies: Levofloxacin		
14. DME and Supplies: feeding pump									
16. Nutrition: full-liquid, NG feeding					18.B. Activities Permitted Up As Tolerated				
18.A. Functional Limitations Endurance					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: 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.				
Homebound status: poor endurance due to severe fatigue					22.B.Discharge Plans patient will be responsible for managing treatment patient will be responsible for managing treatment				
Clinical Condition Requiring Homecare: Pancreatic mass, Gastric outlet obstruction					SN Careplans SN WK1: 1 (08/11/26-08/15/26) ,WK2: 1 (08/16/26-08/22/26) ,WK3: 1 (08/23/26-08/29/26) ,WK4: 1 (08/30/26-09/05/26) ,WK5: 1 (09/06/26-09/09/26) 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: 0. No assistance needed - patient is independent or does not have needs in this area HOSPITALIZATION RISKS: 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:Patient has Durable Power of Attorney for Health Care 08/17/2026 Problems : M1400 - Dyspnea M2020 - Oral Med Management lightheadedness				
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by STRICKLER, SYDNEY SN RN on 08/11/2026					25. Date HHA Received Signed POT				
24. Physician's Name and Address JOHN WILKINS 611 COURT ST WEST BRANCH, MI 48661-8820 PHONE: (989) 345-7000 FAX: 19893457479 NPI: 1689082539					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 : 06/08/2026				
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				

Home Health Certification and Plan of Care				Order ID: 1195/776
1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
X3LM68428909	08/11/2026	From: 08/11/2026 To: 10/09/2026	895	239350
6. Patient's Name and Address Michael Wahl 10550 E AU SABLE RD, SAINT HELEN, MI 48656-9330 (989) 808-2127			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	

limited endurance	
PROCEDURES: Tube feeding: Administer a total of 1440ml of tube feed via NG tube through tube feeding pump. Flush with 30-60ml of water before and after administration of tube feed. Follow specific physician ordered guidlines for advancing rate each day to reach goal as tolerated., Monitor weight: Obtain weekly weights to monitor malnutrition status., cough/deep breathing exercises, incentive spirometer 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 perform tube care administer enteral feeding, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule	

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by STRICKLER, SYDNEY SN RN	08/11/2026