Home Health Certification and Plan of Care

Order ID: 1195/1137

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

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: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home, medical condition could get worse if patient leaves home

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

SN Careplans

SN Goals

PT Careplans

PT WK1: 2 (08/03/26-08/08/26) ,WK2: 2 (08/09/26-08/15/26)

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. 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

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

4 Steps - 06. Independent

Picking Up Object - 06. Independent

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by LUBELAN, SAMANTHA RN SN 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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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

08/06/2026 Problems : GG0170K1 - Walk 150 Feet
GG0130F1 - Upper Body Dressing
GG0130A1 - Eating
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene
GG0170E1 - Chair to Bed to Chair
GG0170P1 - Picking Up Object
GG0170O1 - 12 Steps
GG0170N1 - 4 Steps
GG0170M1 - 1 - Step (curb)
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170J1 - Walk 50 ft with 2 Turns
GG0170I1 - Walk 10 Feet
GG0170G1 - Car Transfer
GG0170F1 - Toilet Transfer
GG0170D1 - Sit to Stand
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
abnormal blood pressure
muscle weakness
limited strength
limited endurance

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

12 Steps - 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 LUBELAN, SAMANTHA RN SN	08/03/2026