Home Health Certification and Plan of Care

Order ID: 1195/1245

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.
RAMIPRIL 2.5 MG mg mouth at bedtime.
PRAVASTATIN 20 MG mg mouth every morning.

11. ICD	Principal Diagnosis	Date
K31.1	Adult hypertrophic pyloric stenosis	08/11/26

13. ICD	Other Pertinent Diagnoses	Date
K86.89	Other specified diseases of pancreas	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

14. DME and Supplies:
feeding pump

15. Safety Measures:
medication safety, fall precautions, standard precautions

16. Nutrition:
full-liquid, NG feeding

17. Allergies:
Levofloxacin

18.A. Functional Limitations
Endurance

18.B. Activities Permitted
Up As Tolerated

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
patient will be responsible for managing treatment

Homebound status: poor endurance due to severe fatigue

Clinical Condition Requiring Homecare: Pancreatic mass, Gastric outlet obstruction

SN Careplans

SN frequency 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

SN Goals

PATIENT-STATED GOAL: Build strength and endurance back up by increasing calorie intake

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
* how to perform tube care
* administer enteral feeding
* recalls related medication(s) purpose, schedule

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

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
2110 M-76 STE 6
WEST BRANCH, MI 48661
PHONE: (989) 345-1184 FAX: 989-345-7910 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.

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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