

|                                                                                                                                                                                                                                                                                                                 |  |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--|
| Home Health Certification and Plan of Care                                                                                                                                                                                                                                                                      |  |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Order ID: 1195/846               |  |
| 1. Patient s HI claim No.                                                                                                                                                                                                                                                                                       |  | 2. Start Of Care Date                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 3. Certification Period          |  |
| 1NK4CD7PQ89                                                                                                                                                                                                                                                                                                     |  | 08/14/2026                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | From: 08/14/2026 To: 10/12/2026  |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4. Medical Record No.            |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 914                              |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Provider No.                  |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 239350                           |  |
| 6. Patient's Name and Address                                                                                                                                                                                                                                                                                   |  |                                                              | 7. Provider's Name, Address and Telephone Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  |  |
| Donald Lauderbaugh<br>17535 Sunrise Lane,<br>HILLMAN, MI 49746-<br>(989) 742-4401                                                                                                                                                                                                                               |  |                                                              | Evergreen Home Health<br>403 W Main Street Suite A1<br>Gaylord, MI 49735-1887<br>989-214-1114<br>1184225021                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  |  |
| 8. DOB                                                                                                                                                                                                                                                                                                          |  |                                                              | 9. Sex                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |  |
| 08/30/1939                                                                                                                                                                                                                                                                                                      |  |                                                              | Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |  |
| 11. ICD                                                                                                                                                                                                                                                                                                         |  | Principal Diagnosis                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Date                             |  |
| S72.142D                                                                                                                                                                                                                                                                                                        |  | Displ intertroch fx l femur subs for clos fx w routn heal    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 08/14/26                         |  |
| 13. ICD                                                                                                                                                                                                                                                                                                         |  | Other Pertinent Diagnoses                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Date                             |  |
| E11.22                                                                                                                                                                                                                                                                                                          |  | Type 2 diabetes mellitus w diabetic chronic kidney disease   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 08/14/26                         |  |
| D50.0                                                                                                                                                                                                                                                                                                           |  | Iron deficiency anemia secondary to blood loss (chronic)     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 08/14/26                         |  |
| I25.10                                                                                                                                                                                                                                                                                                          |  | Athscl heart disease of native coronary artery w/o ang pctrs |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 08/14/26                         |  |
| I48.20                                                                                                                                                                                                                                                                                                          |  | Chronic atrial fibrillation unspecified                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 08/14/26                         |  |
| I50.20                                                                                                                                                                                                                                                                                                          |  | Unspecified systolic (congestive) heart failure              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 08/14/26                         |  |
| N40.1                                                                                                                                                                                                                                                                                                           |  | Benign prostatic hyperplasia with lower urinary tract symp   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 08/14/26                         |  |
| J84.9                                                                                                                                                                                                                                                                                                           |  | Interstitial pulmonary disease unspecified                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 08/14/26                         |  |
| N30.00                                                                                                                                                                                                                                                                                                          |  | Acute cystitis without hematuria                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 08/14/26                         |  |
| K76.82                                                                                                                                                                                                                                                                                                          |  | Hepatic encephalopathy                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 08/14/26                         |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                              | 10. Medications: Dose/Frequency/Route (N)ew (C)hanged                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                              | ACETAMINOPHEN 650 mg by mouth every 6 hours as needed for Pain/Fever<br>ACETIC ACID 30 ml via irrigation every shift Mon, Wed, Fri for catheter use related to OBSTRUCTIVE AND REFLUX UROPATHY, UNSPECIFIED (N13.9)<br>ASCORBIC ACID 500 MG tablet by mouth one time a day for Supplement<br>ASPIRIN 1 tablet by mouth one time a day for Heart Health<br>ATORVASTATIN 10 MG tablet by mouth every day related to<br>ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (I25.10)<br>BIOTIN 5 MG capsule by mouth one time a day for supplementation<br>CO Q 10 200 mg by mouth one time a day for supplementation<br>FARXIGA 5 MG mg by mouth one time a day for Type 2 Diabetes<br>DIGOXIN 1 tablet by mouth one time a day related to CHRONIC ATRIAL FIBRILLATION, UNSPECIFIED (I48.20). Hold for apical pulse DULCOLAX 1 suppository rectally as needed for Constipation if no result from Milk of Magnesia, or Dulcolax suppository rectally at b<br>ELIQUIS 5 MG tablet by mouth two times a day related to CHRONIC ATRIAL FIBRILLATION, UNSPECIFIED (I48.20). On hold from 08/04/2026 13:03<br>ENTRESTO 26 MG tablet by mouth two times a day related to UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE(I50.20).<br>ANEXSIA 7.5/650 1 tablet by mouth one time a day for supplementation<br>FINASTERIDE 5 MG tablet by mouth one time a day for BPH<br>FLOMAX 0.4 MG capsule by mouth at bedtime for benign prostatic hyperplasia (administer with a meal or snack at bedtime per pharmacy<br>FUROSEMIDE 20 MG tablet by mouth one time a day related to UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE(I50.20).<br>LACTULOSE 45 ml by mouth four times a day related to HEPATIC ENCEPHALOPATHY(K76.82)<br>INSULIN 20 unit subcutaneously at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE (E11.22)<br>MAGNESIUM 400 MG tablet by mouth one time a day for supplementation<br>METOPROLOL 25 MG tablet by mouth three times a day for HTN<br>MECLIZINE 200 MG capsule by mouth three times a day for supplementation<br>MILK OF MAGNESIA 30 ml by mouth every 72 hours as needed for For constipation if no bowel movement for 3 days UNLESS RESIDENT IS ON NALOXONE 0.4 MG ml intramuscularly as needed for Suspected Opiod Overdose. Administer 1ml of Narcan if opioid overdose is suspected. If NYSTATIN 100000 UNIT Apply to groin, scrotum, penis topically every day and evening shift for excoriation d/c order once resolved<br>OMEGA-3 500 mg by mouth one time a day for supplementation<br>ONDANSETRON 4 MG tablet by mouth every 6 hours as needed for Nausea and Vomiting<br>PRESERVISION 1 capsule by mouth two times a day for supplementation<br>BACITRACIN ZINC AND POLYMYXIN B SULFATE 20 % Apply to groin folds/buttocks topically every shift for redness |                                  |  |
| 14. DME and Supplies:                                                                                                                                                                                                                                                                                           |  |                                                              | 15. Safety Measures:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |  |
| walker                                                                                                                                                                                                                                                                                                          |  |                                                              | standard precautions, fall precautions, diabetic precautions, bleeding precautions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |  |
| 16. Nutrition:                                                                                                                                                                                                                                                                                                  |  |                                                              | 17. Allergies:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |  |
| regular                                                                                                                                                                                                                                                                                                         |  |                                                              | no known allergies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |  |
| 18.A. Functional Limitations                                                                                                                                                                                                                                                                                    |  |                                                              | 18.B. Activities Permitted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  |  |
| Ambulation, Bowel/Bladder Incontinence                                                                                                                                                                                                                                                                          |  |                                                              | Exercises Prescribed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |  |
| 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: 8. Patient unable to respond, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |  |
| 20. Prognosis:                                                                                                                                                                                                                                                                                                  |  |                                                              | good                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |  |
| 22. A Rehabilitation Potential:                                                                                                                                                                                                                                                                                 |  |                                                              | 22.B.Discharge Plans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |  |
| 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. |  |                                                              | patient will be responsible for managing treatment<br>add discharge plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                  |  |
| Homebound status: medical condition could get worse if patient leaves home                                                                                                                                                                                                                                      |  |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |  |
| 23. Signature and Date of Verbal SOC Where Applicable:                                                                                                                                                                                                                                                          |  |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 25. Date HHA Received Signed POT |  |
| Electronically Signed by LUBELAN, SAMANTHA RN SN on 08/14/2026                                                                                                                                                                                                                                                  |  |                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |  |
| 24. Physician's Name and Address                                                                                                                                                                                                                                                                                |  |                                                              | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                  |  |
| DAVID DARGIS<br>109 S 13 HARRINGTON ST<br>ALPENA, MI 49707-1609<br>PHONE: (989) 356-2400 FAX: 19893542606 NPI: 1457490609                                                                                                                                                                                       |  |                                                              | F2F date :                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  |  |
| 27. Attending Physician's Signature and Date Signed                                                                                                                                                                                                                                                             |  |                                                              | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                  |  |
| 08/26/2026 Date of physician last face-to-face                                                                                                                                                                                                                                                                  |  |                                                              | PAGE 1 of 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  |  |

| Home Health Certification and Plan of Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                       |                                                                                                                                                                 | Order ID: 1195/846                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                       |                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------|
| 1. Patient s HI claim No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 2. Start Of Care Date | 3. Certification Period                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. Medical Record No. | 5. Provider No. |
| 1NK4CD7PQ89                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 08/14/2026            | From: 08/14/2026 To: 10/12/2026                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 914                   | 239350          |
| 6. Patient's Name and Address<br>Donald Lauderbaugh<br>17535 Sunrise Lane,<br>HILLMAN, MI 49746-<br>(989) 742-4401                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                       | 7. Provider's Name, Address and Telephone Number<br>Evergreen Home Health<br>403 W Main Street Suite A1<br>Gaylord, MI 49735-1887<br>989-214-1114<br>1184225021 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                       |                 |
| Clinical Condition - Home health referral ordered at time of discharge for PT/OT services. Source: Home Health Referral Order dated 08/12/2026, PDF p. 13. - Recent course includes a Requiring Homecare: left intertrochanteric femur fracture treated with left trochanteric nailing on 06/04/2026, followed by skilled rehabilitation. Therapy notes document continued work on lower-extremity/core strength, balance, gait, transfers, ADLs, and discharge planning. Source: NP/PA Progress Note dated 08/10/2026, PDF p. 16; PT notes dated 08/10/2026 and 08/11/2026, PDF pp. 57-58; OT note dated 08/11/2026, PDF p. 14. - Active issues during the SNF stay also included chronic Foley catheter management/UTI monitoring, chronic anemia with low hemoglobin and positive hemoccult testing, and a left-hand skin wound. Source: Medication Review/Orders, PDF pp. 4-9; Progress Notes, PDF pp. 16-56.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                       |                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                       |                 |
| SN Careplans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                       |                                                                                                                                                                 | SN Goals                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                       |                 |
| PT Careplans<br>PT WK1: 1 (08/14/26-08/15/26) ,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 (09/06/26-09/12/26) ,WK6: 1 (09/13/26-09/19/26) ,WK7: 1 (09/20/26-09/26/26) ,WK8: 1 (09/27/26-10/03/26) ,WK9: 1 (10/04/26-10/10/26)<br><br>PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 94 > 101.0, heart rate < 50 > 100, respiratory rate < 12 > 20, blood pressure systolic < 90 > 150, blood pressure diastolic < 50 > 100, O2 saturation < 90 > 100, pain < 0 > 7<br><br>CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance<br><br>HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 7. Currently taking 5 or more medications, 9. Other risk(s) not listed in 1- 8<br><br>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.<br>Advance Directive:Refer to Medical Record<br><br>08/25/2026 Problems : GG0170D1 - Sit to Stand<br>GG0170P1 - Picking Up Object<br>GG0170O1 - 12 Steps<br>GG0170N1 - 4 Steps<br>GG0170M1 - 1 - Step (curb)<br>GG0170L1 - Walk 10 ft on Uneven Surface<br>GG0170K1 - Walk 150 Feet<br>GG0170J1 - Walk 50 ft with 2 Turns<br>GG0170I1 - Walk 10 Feet<br>GG0170G1 - Car Transfer<br>GG0170E1 - Chair to Bed to Chair<br>GG0170F1 - Toilet Transfer<br>M1610 - Urinary Catheter<br>Pain Effect on Sleep<br>Pain Interference with Therapy activities<br>Pain Interference with ADLs<br>M1400 - Dyspnea<br>M2020 - Oral Med Management<br>limited endurance<br>limited strength<br>M2102c - Med Admin |  |                       |                                                                                                                                                                 | PT Goals<br>PATIENT-STATED GOAL: Patient Goal<br><br>GOALS<br>Chair to Bed to Chair - 06. Independent<br><br>Toilet Transfer - 06. Independent<br><br>Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance<br><br>1 - Step (curb) - 05. Setup or clean-up assistance<br><br>patient/caregiver recalls<br>* lifestyle modifications to manage respiratory condition including<br>* diet changes and regular exercise<br>* strategies to control shortness of breath<br>* home remedies to keep lungs healthy<br>* recalls related medication(s) purpose, schedule<br><br>patient/caregiver recalls<br>* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain<br>* teach relaxation skills and diversional activities<br>* recalls related medication(s) purpose, schedule<br><br>patient/caregiver recalls<br>* urinary catheter management including how to flush catheter<br>* change and wash drainage bags<br>* prevent infection including proper handwashing<br>* positioning of catheter<br>* recalls related medication(s) purpose, schedule<br><br>patient self-administers medications as prescribed<br>* recalls related medication(s) purpose, schedule<br><br>caregiver administers and/or packages medications appropriately<br><br>Sit to Stand - 06. Independent<br><br>Car Transfer - 06. Independent<br><br>Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance<br><br>Walk 150 Feet - 05. Setup or clean-up assistance<br><br>4 Steps - 05. Setup or clean-up assistance<br><br>12 Steps - 05. Setup or clean-up assistance<br><br>Picking Up Object - 05. Setup or clean-up assistance<br><br>Walk 10 Feet - 05. Setup or clean-up assistance |                       |                 |
| Signature of Physician:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                       |                                                                                                                                                                 | Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                       |                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                       |                                                                                                                                                                 | PAGE 2 of 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                       |                 |
| Optional Name/Signature of Nurse/Therapist:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                       |                                                                                                                                                                 | Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                       |                 |
| Electronically Signed by LUBELAN, SAMANTHA RN SN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                       |                                                                                                                                                                 | 08/14/2026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                       |                 |

| Home Health Certification and Plan of Care                                                                         |                       |                                                                                                                                                                 |                       | Order ID: 1195/846 |
|--------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------|
| 1. Patient s HI claim No.                                                                                          | 2. Start Of Care Date | 3. Certification Period                                                                                                                                         | 4. Medical Record No. | 5. Provider No.    |
| 1NK4CD7PQ89                                                                                                        | 08/14/2026            | From: 08/14/2026 To: 10/12/2026                                                                                                                                 | 914                   | 239350             |
| 6. Patient's Name and Address<br>Donald Lauderbaugh<br>17535 Sunrise Lane,<br>HILLMAN, MI 49746-<br>(989) 742-4401 |                       | 7. Provider's Name, Address and Telephone Number<br>Evergreen Home Health<br>403 W Main Street Suite A1<br>Gaylord, MI 49735-1887<br>989-214-1114<br>1184225021 |                       |                    |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| <p>PROCEDURES: Manual Therapy: Manual therapy may include manually resisted or assisted range of motion to the joints of the right or left lower extremity; manual muscle stretching to decrease muscular tension and improve range of motion for improved transfers in and out of vehicle., Manual Therapy: Manual therapy may include manually resisted or assisted range of motion to the joints of the right or left lower extremity; manual muscle stretching to decrease muscular tension and improve range of motion for improved transfers in and out of vehicle., cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, monitor intake &amp; output, home exercise program: Therapist to instruct seated, standing and/or reclined home exercises including but not limited to any or all of the following as tolerated: active or band resisted/assisted ankle pumps, circumduction, hip flexion, adduction, and/or abduction, range of motion for Lower extremity joints of knees, hips, and/or ankle/foot. Core strengthening; neuromuscular education. Written home exercises provided and program may be modified and/or progressed as tolerated., equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training, teach/coordinate/arrange medication packaging and/or administration</p> <p>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 maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * urinary catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance</p> |                                                                                  |
| <p>OT Careplans</p> <p>OT WK2: 1 (08/16/26-08/22/26)</p> <p>08/22/2026 Problems : Pain Interference with ADLs<br/>M1400<br/>GG0130A1 - Eating<br/>GG0130B1 - Oral Hygiene<br/>GG0130F1 - Upper Body Dressing<br/>GG0130G1 - Lower Body Dressing<br/>GG0130H1 - Don/Doff Footwear<br/>GG0130E1 - Shower/Bathe Self<br/>GG0130C1 - Toileting Hygiene</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>OT Goals</p> <p>PATIENT-STATED GOAL: add patient-stated goal</p> <p>GOALS</p> |

|                                                  |             |
|--------------------------------------------------|-------------|
| Signature of Physician:                          | Date        |
|                                                  | PAGE 3 of 3 |
| Optional Name/Signature of Nurse/Therapist:      | Date        |
| Electronically Signed by LUBELAN, SAMANTHA RN SN | 08/14/2026  |