Home Health Certification and Plan of Care

Order ID: 1195/1388

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
4AG2JX5GT28	08/25/2026	From: 08/25/2026 To: 10/23/2026	943	239350

6. Patient's Name and Address
Donald Macnaughton
718 STATE ST,
EAST JORDAN, MI 49727-
(231)676-2188

7. Provider's Name, Address and Telephone Number
Evergreen Home Health
403 W Main Street Suite A1
Gaylord, MI 49735-1887
989-214-1114
1184225021

8. DOB 12/22/1951 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I44.2	Atrioventricular block complete	08/25/26

13. ICD	Other Pertinent Diagnoses	Date
R55.	Syncope and collapse	08/25/26
I95.1	Orthostatic hypotension	08/25/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	08/25/26
I48.19	Other persistent atrial fibrillation	08/25/26
I10.	Essential (primary) hypertension	08/25/26
E78.5	Hyperlipidemia unspecified	08/25/26
N18.30	Chronic kidney disease stage 3 unspecified	08/25/26
E44.0	Moderate protein-calorie malnutrition	08/25/26

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

PROTONIX 40 mg Oral Daily
Sotalol Hydrochloride - Sotalol Hydrochloride .5 by mouth twice a day
TYLENOL 650 mg Oral Q4H, PRN
ATORVASTATIN 80 mg Oral QHS
TRAZODONE 100 mg Oral QHS, PRN
Vitamin D3 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000 by mouth once a day
ASPIRIN 81 mg Oral Daily
HYDROcodone-acetaminophen 5 mg-325 mg Oral Q4H, PRN

14. DME and Supplies:
None of the above

15. Safety Measures:
No lifting left arm above head

16. Nutrition:
regular

17. Allergies:
Bacitracin Zinc (Rash), Neomycin Sulfate (Rash), Pollen (Nose running, Watery e
gramicidin topical (Unknown), polymyxin B sulfate (Unknown)

18.A. Functional Limitations
Ambulation

18.B. Activities Permitted
None of the above

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

22.B.Discharge Plans
SN: patient will be responsible for managing treatment
PT: add discharge plan

Homebound status: medical condition could get worse if patient leaves home

Clinical Condition Requiring Homecare: - Discharge planning documents anticipated transition home independently with home health and states the patient was open to visiting nurse services; referral to McLaren Home Health was sent. The hospitalization was for recurrent syncope/near-syncope with a fall while walking to check the mail, associated with bradycardia and concern for high-grade atrioventricular block. - Recent hospital course: The patient presented after a recurrent syncopal episode and fall. He had a similar July 2026 admission with significant bradycardia while on sotalol. During the current admission, telemetry showed a rare episode of a dropped QRS complex following a P wave, raising concern for high-grade AV block. Cardiology documented syncope likely secondary to high-grade AV block, recommended permanent pacemaker implantation during the hospitalization, and recommended discontinuing sotalol because of recurrent bradycardia. CT brain showed no acute intracranial process. The right elbow had a mild abrasion from the fall and was improving/open to air. Nutrition assessment identified moderate starvation-related malnutrition with significant unintentional weight loss and recommended Ensure Plus High Protein twice daily with meals.

SN Careplans

SN frequency Auth ID 669 WK1: 1 (08/25/26-08/29/26),Auth ID 669 WK2: 1 (08/30/26-09/05/26),Auth ID 669 WK3: 1 (09/06/26-09/12/26),Auth ID 669 WK4: 1 (09/13/26-09/19/26),Auth ID 669 WK5: 1 (09/20/26-09/26/26),Auth ID 669 WK6: 1 (09/27/26-10/03/26),Auth ID 669 WK7: 1 (10/04/26-10/10/26),Auth ID 669 WK8: 1 (10/11/26-10/17/26),Auth ID 669 WK9: 1 (10/18/26-10/23/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 94 > 101.0, heart rate < 50 > 100, respiratory rate < 12 > 20, blood pressure systolic < 90 > 150, blood pressure diastolic < 60 > 100, O2 saturation < 90 > 100, pain < 0 > 7

CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 3. Multiple hospitalizations (2 or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 7. Currently taking 5 or more medications

STANDING ORDERS: Home Health Clinician to provide ongoing patient and caregiver education regarding prevention of skin breakdown and pressure injuries during the home health episode as clinically indicated.; Home Health Clinician to assess fall risk and provide ongoing patient and caregiver education regarding fall prevention and home safety measures throughout the home health episode as clinically indicated.; Home Health Clinician to assess, monitor, educate, and implement non-pharmacological pain management interventions as clinically indicated throughout the home health episode. Notify physician/authorized provider of uncontrolled pain, significant changes in pain status, or adverse medication effects.; Home Health Clinician to assess, monitor, and provide patient/caregiver education regarding mood status, signs and symptoms of 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

SN Goals

PATIENT-STATED GOAL: No falls and get stronger

GOALS
patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by LUBELAN, SAMANTHA RN SN on 08/25/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
JONATHAN JOLIAT
4600 INVESTMENT DR SUITE 300
TROY, MI 48098-6365
PHONE: (248) 267-5000 FAX: 12482675001 NPI: 1780847756

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

F2F date : 08/20/2026

27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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Implement standard and transmission based infection control precautions as indicated and provide ongoing patient/caregiver education regarding infection prevention throughout the home health episode. Notify physician/authorized provider of suspected or confirmed infection or clinical deterioration.; Home Health Clinician to assess, review, and reinforce patient/caregiver emergency preparedness plan throughout the home health episode, recertifications and resumptions of care.; Home Health Clinician to assess patient advance directive status and provide education regarding advance care planning throughout the home health episode. Assist with identification, completion, or updating of advance directive documents as appropriate and within scope of practice.
Advance Directive:Self (Non-HC Facilitated)

08/25/2026 Problems : M1400 - Dyspnea
M2020 - Oral Med Management
lightheadedness
abnormal blood pressure
muscle weakness
frequent urination
B1000 - Vision Deficit
D0160 - Depression

PROCEDURES: Shower: Nurse to supervise patient with shower, Medication set up: Nurse to complete medication set up during nurse visit and medication education., Surgical site care for Pacemaker placement : Keep area clean and dry. Monitor for s/sx of infection, cough/deep breathing exercises, incentive spirometer, monitor intake & output, coordinate/arrange resources for vision-impaired

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule

PT Careplans

PT frequency Auth ID 694 WK2: 1 (08/30/26-09/05/26)

09/08/2026 Problems : GG0170D1 - Sit to Stand
GG0170F1 - Toilet Transfer
GG0170G1 - Car Transfer
GG0170I1 - Walk 10 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170K1 - Walk 150 Feet
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170M1 - 1 - Step (curb)
GG0170N1 - 4 Steps
GG0170O1 - 12 Steps
GG0170P1 - Picking Up Object
GG0170E1 - Chair to Bed to Chair

PROCEDURES: home exercise program, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT Goals

GOALS

Eval only no further treatment needed at this time.

OT Careplans

OT frequency Auth ID 695 WK3: 1 (09/06/26-09/12/26)

09/08/2026 Problems : Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400
GG0130B1 - Oral Hygiene
GG0130C1 - Toileting Hygiene
GG0130E1 - Shower/Bathe Self
GG0130G1 - Lower Body Dressing
GG0130H1 - Don/Doff Footwear
GG0130A1 - Eating
GG0130F1 - Upper Body Dressing

OT Goals

Signature of Physician:	Date

Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by LUBELAN, SAMANTHA RN SN	08/25/2026