Home Health Certification and Plan of Care

Order ID: 1195/1326

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
X3LM67042753	08/26/2026	From: 08/26/2026 To: 10/24/2026	859	239350

6. Patient's Name and Address
Patricia Perry
1702 DOLLAR LAKE RD,
LEWISTON, MI 49756-
734-280-1617

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 05/24/1940 **9.Sex** Female

11. ICD	Principal Diagnosis	Date
T18.128A	Food in esophagus causing other injury initial encounter	08/26/26

13. ICD	Other Pertinent Diagnoses	Date
K21.00	Gastro-esophageal reflux dis with esophagitis without bleed	08/26/26
I10.	Essential (primary) hypertension	08/26/26
E03.9	Hypothyroidism unspecified	08/26/26

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

ACETAMINOPHEN 500 MG tablet by mouth every 6 hours as needed for Pain Commonly known as: TYLENOL
FUROSEMIDE 20 mg tablet by mouth daily Commonly known as: Lasix
LOSARTAN POTASSIUM 100 MG tablet by mouth daily Commonly known as: COZAAR
Metoprolol Succinate - Metoprolol Succinate eq 25 mg tartrate 1/2 (half tablet) by mouth once a day
Omeprazole - Omeprazole 20 mg 1 by mouth once a day
LEVOTHYROXINE 50 mcg tablet by mouth every morning (before breakfast) Commonly known as: Synthroid
Saga Pro Bladder Health - Angelica 100 MG by mouth once a day
Beet Root 1300 mg 1300 MG by mouth twice a day

14. DME and Supplies:
oxygen supplies, grab bars, bath bench, cane

15. Safety Measures:
fall precautions, ambulates with device

16. Nutrition:
regular

17. Allergies:
sulfa drugs!ergod

18.A. Functional Limitations
Endurance, Bowel/Bladder Incontinence, Hearing

18.B. Activities Permitted
Cane, Up As Tolerated, Independent at Home

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: good

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

22.B.Discharge Plans
SN: patient will be responsible for managing treatment

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

Clinical Condition Requiring Homecare: - Referral is for skilled home care after hospitalization, including skilled nursing for medication reconciliation and teaching/assessment of disease management. Home oxygen and related durable medical equipment were also ordered. (Source: After Visit Summary, pages 4-5 of 5) - Patient was hospitalized from 07/25/2026 through 07/28/2026 for food impaction of the esophagus. Discharge follow-up includes gastroenterology follow-up and EGD dilation. During oxygen evaluation, SpO2 was 94% at rest on room air and 87% with exercise on room air; oxygen at 2 L/min increased exercise SpO2 to 92%. (Source: Referral admission information; After Visit Summary, page 2 of 5)

SN Careplans

SN frequency Auth 07292026DOM758735 WK1: 1 (08/26/26-08/29/26),Auth 07292026DOM758735 WK2: 1 (08/30/26-09/05/26),Auth 07292026DOM758735 WK3: 1 (09/06/26-09/12/26),Auth 07292026DOM758735 WK4: 1 (09/13/26-09/19/26),Auth 07292026DOM758735 WK5: 1 (09/20/26-09/26/26),Auth 07292026DOM758735 WK6: 1 (09/27/26-09/27/26)

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

CAREGIVER: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

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

SN Goals

PATIENT-STATED GOAL: Regulate BP and not need anymore esophagus surgeries

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
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by GRANDCHAMP, SAVANNAH SN RN on 08/26/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
DONALD COUSINEAU
994 N CENTER STREET
GAYLORD, MI 49735
PHONE: (989) 732-7843 FAX: 19897314513 NPI: 1841485133

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 :

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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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:No Advance Directive

08/26/2026 Problems : M1610 - Urinary Incontinence
M1033 - Exhaustion
M1400 - Dyspnea
M2020 - Oral Med Management
limited strength
limited endurance
abnormal thyroid <> 0.40 - 4.50 mIU/mL

PROCEDURES: Assess BP : Assess VS Q visit per protocol, pay close attention to BP and report any findings over 150/90 to provider., cough/deep breathing exercises, incentive spirometer, bladder training

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, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by GRANDCHAMP, SAVANNAH SN RN	08/26/2026