HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951457

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
X3LM62093889	08/01/2026	08/01/2026 - 09/29/2026	867	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Kathleen Moore 325 Johnson St ALPENA, MI 99923	Female	01/27/1953	989-306-7945
	Email		Primary Language

Clinical Profile

Provider's Name	Address	Phone Number
Evergreen Home Health	403 W Main Street Suite A1 Gaylord, MI 49735	989-214-1114
NPI 1184225021		Fax Number 866-410-7843

Clinical Condition Requiring Homecare:	Physician Statement on Homebound Status:
Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing care, physical therapy and/or speech therapy. Due to cognitive changes, patient needs ongoing help to set up her medications for safety reasons.	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

ICD-10 CM Principal Diagnosis: G70.00. Myasthenia gravis without (acute) exacerbation

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
R53.1	Weakness	Cephalexin - Cephalexin eq 500 mg base by mouth four times a day COLD CAPSULE IV 1,000 (120-180) mg by mouth daily with breakfast Take 1 g by mouth daily with breakfast. EFAVIRENZ 200MG SCORED TABLETS 200 mg by mouth daily Take 1.5 tablets (300 mg total) by mouth daily. FUROSEMIDE 20 mg by mouth every other day Take 1 tablet (20 mg total) by mouth daily. OMEPRAZOLE 20 mg by mouth daily Take 1 capsule (20 mg total) by mouth daily. LEVOTHYROXINE 25 mcg by mouth daily TAKE 1 TABLET BY MOUTH DAILY EXCEPT 2 TABLETS ON MONDAY AND FRIDAY. PREDNISONE 20 mg by mouth daily Take 60 mg by mouth daily. METFORMIN 500 mg by mouth daily with breakfast Take 1 tablet (500 mg total) by mouth daily with breakfast. MULTIVITAMIN by mouth daily Take 1 tablet by mouth daily. POTASSIUM 20 mEq by mouth every other day Take 1 tablet (20 mEq total) by mouth daily with breakfast. PRAVASTATIN 10 mg by mouth daily Take 1 tablet (10 mg total) by mouth daily. Vit B12 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000mcg by mouth once a day VITAMIN by mouth daily Take 1,000 Units/hr by mouth. Coq10 - Coenzyme Q10 100mg by mouth once a day OXYBUTYNIN 5 mg by mouth 3 (three) times a day Take 1 tablet (5 mg total) by mouth 3 (three) times a day. anticb/db/dha/epa/fut/zeax blood sugar diagnostic (strip) Test once daily blood-glucose meter (misc) test once daily lancets (misc) 28 gauge test once daily
M05.79	Rheu arthritis w rheu factor mult site w/o org/sys involv	
R41.89	Oth symptoms and signs w cognitive functions and awareness	
R60.0	Localized edema	
N32.81	Overactive bladder	
R93.89	Abnormal findings on dx imaging of oth body structures	

Prognosis	Mental and Psychosocial Status
good	COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes
Functional Limitations	**Activities Permitted**
Speech, Bowel/Bladder Incontinence, Endurance, Ambulation	Up As Tolerated, Walker

DME & Supplies	Safety Measures
grab bars, bath bench, diabetic supplies, rolling walker	walker precautions, medication safety, fall precautions, diabetic precautions, ambulates with device, , medical alert/lifeline, standard precautions, hand rails, bathroom safety
Nutrition	**Allergies**
Z. NO PHYSICIAN-ORDERED DIET	no known allergies

Advance Directives
DPOA - Pamela Merrifield

Living will

Caregiver Status
3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance; 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

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.

DISCHARGE PLAN:
SN: patient will be responsible for managing treatment
PT: family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

PT Eval

SN CAREPLAN

SN frequency WK1: 1 (08/01/26-08/01/26),WK2: 2 (08/02/26-08/08/26),WK3: 2 (08/09/26-08/15/26),WK4: 2 (08/16/26-08/22/26),WK5: 2 (08/23/26-08/29/26)

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

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

Living will

08/01/2026 Problems : D0700 - Social Isolation
M1610 - Urinary Incontinence
M1033 - Exhaustion
M1400 - Dyspnea
M2020 - Oral Med Management
dependent edema
impaired speech
balance deficit
limited strength
muscle weakness
limited endurance
cough/gag/pain chew/swallow
M2102c - Med Admin
D0160 - Depression
M2102f - Patient Supervision
M2102d - Caregiver Performs Treatment

PROCEDURES: cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, bladder training, teach/coordinate/arrange medication packaging and/or administration,

SN NARRATIVE

RN knocked and was verbally invited into home by patient and brother. RN joined patient in living room. She is sitting in recliner with legs elevated. Admission documents reviewed and signed. Head to toe assessment completed and vitals obtained. Vitals stable. Patient has +1 pitting edema to BLE, which is apparently a significant improvement from previous. Her neurologist at U of M Is questioning whether Myesthenia Gravis is the appropriate diagnosis for the patient due to the typical treatment causing worsening symptoms for her. Some bloodwork was just drawn to test for LEMS. Awaiting results. Her doctor is tapering her prednisone down by 5mg per week on Wednesdays. She is currently taking 20mg per day. Patient and brother report her "brain fog" has been becoming gradually worse. Patient requires assistance with med sets and ensuring she is taking appropriate meds at appropriate times. She is agreeable with SN and PT with the potential for nurse aide if deemed appropriate later. Visit plan will be twice per week for 2 weeks, then once per week thereafter.

SOC assessment completed and vitals obtained. Patient agreeable with POC.

SN GOALS

PATIENT-STATED GOAL: Be more stable at home

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

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

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

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

patient/caregiver recalls

coordinate/arrange for adequate patient supervision, coordinate/arrange long-term socialization activities 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 optimize mental status with cognition therapy home safety optimize mobility with active and passive range of motion therapeutic exercises diet and fluids to optimize peripheral circulation, 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, * 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, * strategies to increase socialization, related medication(s) purpose, schedule, patient is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence	* how to optimize mental status with cognition therapy * home safety * optimize mobility with active and passive range of motion therapeutic exercises * diet and fluids to optimize peripheral circulation * recalls related medication(s) purpose, schedule

PT CAREPLAN
PT frequency WK2: 1 (08/02/26-08/08/26),WK3: 1 (08/09/26-08/15/26),WK4: 2 (08/16/26-08/22/26),WK5: 1 (08/23/26-08/29/26)

09/05/2026 Problems : GG0170G1 - Car Transfer
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130F1 - Upper Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170E1 - Chair to Bed to Chair
GG0170D1 - Sit to Stand
GG0170P1 - Picking Up Object
GG0170O1 - 12 Steps
GG0170N1 - 4 Steps
GG0170M1 - 1 - Step (curb)
GG0170K1 - Walk 150 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170I1 - Walk 10 Feet
GG0170F1 - Toilet Transfer

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., 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/stair training, transfers training

TEACH PATIENT/CAREGIVER: Chair to Bed to Chair - 05. Setup or clean-up assistance, Sit to Stand - 05. Setup or clean-up assistance, Toilet Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance

PT NARRATIVE
Additional Contacts:Caregiver Sharlet: (989) 464-4750Sandy (neighbor): 989-354-4542.Brother Steven: 708-207-0266.The patient has not yet made progress toward functional goals, participates in care, but tolerated PT interventions with poor follow-through at today's visit. Gait training performed with patient ambulating a distance of 40 feet in one attempt, using rolling walker for safety. Patient was given mod verbal cues for proximity to chair with chair transfer, turning and keeping walker in arms reach. Patient and caregiver given feedback regarding observation of ptnt pushing walker outside reach when sitting. The patient would continue to benefit from continued physical therapy services in order promote greater independence and decrease risk of falls and further hospitalizations. Progress has been slowed by medical comorbidities and safety concerns, confusion and vitals outside WNL.

PT GOALS
PATIENT-STATED GOAL: Goal

GOALS
Toilet Transfer - 06. Independent

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 08/01/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.
F2F date: 07/29/2026

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.

Certifying Physician or Allowed Practitioner Name and Address **CHRISTY WERTH**
211 LONG RAPIDS RD
ALPENA, MI 49707-1315
NPI 1750390498

Phone Number (989) 354-2142

Fax Number 19893548600

Physician's Signature and Date Signed

X

CHRISTY WERTH, DO
07/29/2026: Date of physician last face-to-face