HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195836

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
80017650600	08/13/2026	08/13/2026 - 10/11/2026	886	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Bruce Burr 3100 PARK RD LUZERNE, MI 48636	Male	01/17/1960	(989) 390-8249
	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:
post cardiothoracic surgery	symptoms identified support difficulty to leave home for medical services required.

ICD-10 CM Principal Diagnosis: Z48.812. Encntr for surgical aftcr following surgery on the circ sys

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
I35.0	Nonrheumatic aortic (valve) stenosis	ADVAIR 250 mcg-50 mcg/inh inhalation powder BID 1 inh ATORVASTATIN 20 mg oral tablet Daily 20 mg= 1 Tab, 3 refills Breztri Aerosphere 160 mcg-9 mcg-4.8 mcg/inh inhalation aerosol BID 2 Puff, inh, 3 refills ELIQUIS 5 mg oral tablet BID 5 mg= 1 Tab, 3 refills LISINOPRIL 2.5 mg oral tablet BID 2.5 mg= 1 Tab, 3 refills NITROGLYCERIN 0.4 mg sublingual tablet q4h, PRN 0.4 mg= 1 Tab, 2 refills ROPINIROLE HYDROCHLORIDE 0.5 mg oral tablet QHS 2 Tab, 3 refills TYLENOL 500 mg oral tablet q4hr, PRN 1000 mg= 2 Tab VENTOLIN 90 mcg/inh inhalation aerosol ONCE, PRN 2 Puff, Inh, 1 refills Potassium Chloride - Potassium Chloride 20MEQ 2 tabs by mouth once a day Metformin - Metformin Hydrochloride 500mg 1 tab by mouth twice a day Bumetanide - Bumetanide 2 mg 1 tab by mouth once a day Gabapentin - Gabapentin 100 mg 1-2 caps by mouth three times a day PRN breakthrough pain Pantoprazole - Pantoprazole Sodium 40 mg 1 tab by mouth before meal
I50.21	Acute systolic (congestive) heart failure	
I48.92	Unspecified atrial flutter	
I48.0	Paroxysmal atrial fibrillation	
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	
E11.65	Type 2 diabetes mellitus with hyperglycemia	

Prognosis	Mental and Psychosocial Status
good	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
Functional Limitations	**Activities Permitted**
Endurance, Hearing, Ambulation	Cane, Walker, Up As Tolerated
DME & Supplies	**Safety Measures**
diabetic supplies, walker, cane	walker precautions, medication safety, infectious material management, fall precautions, diabetic precautions, ambulates with device, cardiac precautions, bathroom safety, anticoagulant precautions
Nutrition	**Allergies**
high protein, cardiac diet	Cipro, Latex, methylPREDNISolone, morphine, niacin, Pollen, predniSONE

Advance Directives
No Advance Directive

Caregiver Status
1. Non-agency caregiver(s) currently provide assistance; 0. No assistance needed - patient is independent or does not have needs in this area

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:
patient will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

4 - Recertification

SN CAREPLAN

SN frequency WK1: 1 (08/13/26-08/15/26),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 (10/04/26-10/09/26)

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

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

HOSPITALIZATION RISKS: 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:No Advance Directive

08/17/2026 Problems : #1 - Observable Surgical Wound - Anterior Midline - Open heart surgery
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
dizziness/syncope
dependent edema
balance deficit
muscle weakness
limited strength
limited endurance
heartburn/indigestion
rough/scaly/cracked skin
bruising/discoloration
abnormal BS < 70/140 > mg/dL
B1000 - Vision Deficit

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Midline - Open heart surgery: clean with wound cleanser spray, leave open to air, monitor for s/s of infection, cough/deep breathing exercises, glucose testing via monitor, coordinate/arrange resources for vision-impaired

SN NARRATIVE

Frequency: Once weekly

Pt states couldn't breathe walked to the mailbox and up to the porch and stated doesn't think he's going to make it. Pts wife took pt to the ER. Admitted Grayling hospital 7/27 transferred to Munson TC 7/29, discharged 8/10. Pt ambulates with cane or walker depending on distance/balance. Open heart surgery new valve placed. Edema BLE pitting +3. VS within normal parameters for pt, assessment completed. Pt states pain 5/10 on chest from bruising/surgery. Pt states is having random few dizzy spells. Checks BS daily, today BS was 124.

- Referral for RN home health services under the Open Heart Pathway following cardiothoracic surgery. The order states that symptoms support difficulty leaving home for required medical services and directs vital sign and weight monitoring.
- The patient was transferred from Grayling ED to Munson Medical Center for acute decompensated heart failure, exertional dyspnea, exertional left anterior chest pain, orthopnea, leg swelling, and atrial flutter. Evaluation showed severe stenosis of the prior bioprosthetic aortic valve and reduced ejection fraction of 35%-40%. On 08/03/2026, he underwent redo sternotomy, explantation of the prior 23 mm Magna tissue aortic valve, and aortic valve replacement with a 23 mm Edwards Inspiris Resilia aortic valve.

Pt states couldn't breathe walked to the mailbox and up to the porch and stated doesn't think he's going to make it. Pts wife took pt to the ER. Admitted Grayling hospital 7/27 transferred to Munson TC 7/29, discharged 8/10. Pt ambulates with cane or walker depending on distance/balance. Open heart surgery new valve placed. Edema BLE pitting +3. VS within normal parameters for pt, assessment completed. Pt states pain 5/10 on chest from bruising/surgery. Pt states is having random few dizzy spells.

- Referral for RN home health services under the Open Heart Pathway following cardiothoracic surgery. The order states that symptoms support difficulty leaving home for required medical services and directs vital sign and weight monitoring.
- The patient was transferred from Grayling ED to Munson Medical Center for acute decompensated heart failure, exertional dyspnea, exertional left anterior chest pain, orthopnea, leg swelling, and atrial flutter. Evaluation showed severe stenosis of the prior bioprosthetic aortic valve and reduced ejection fraction of 35%-40%. On 08/03/2026, he underwent redo sternotomy, explantation of the prior 23 mm Magna tissue aortic valve, and aortic valve replacement with a 23 mm Edwards Inspiris Resilia aortic valve.

Frequency: once weekly
PCP: Dr. Nigrelli Grayling f/u 4-6 weeks
Cardiac: Yelevarthy TC heart and vascular f/u9/2 9am
Cardiothoracic surgeons of Grand traverse: f/u 8/24 11am

Upon arrival greeted by pt and spouse on front porch, SOC completed on front porch. Lives with daughter and spouse- 1 dog. Pt states couldn't breathe walked to the mailbox and up to the porch and stated doesn't think he's going to make it. Pts wife took pt to the ER. Admitted Grayling hospital 7/27 transferred to Munson TC 7/29, discharged 8/10. Pt ambulates with cane or walker depending on distance/balance. Open heart surgery new valve placed. Edema BLE pitting +3. VS within normal parameters for pt, assessment completed. Pt states pain 5/10 on chest from bruising/surgery. Pt states is having random few dizzy spells.

- Referral for RN home health services under the Open Heart Pathway following cardiothoracic surgery. The order states that symptoms support difficulty leaving home for required medical services and directs vital sign and weight monitoring.
- The patient was transferred from Grayling ED to Munson Medical Center for acute decompensated heart failure, exertional dyspnea, exertional left anterior chest pain, orthopnea, leg swelling, and atrial flutter. Evaluation showed severe stenosis of the prior bioprosthetic aortic valve and reduced ejection fraction of 35%-40%. On 08/03/2026, he underwent redo sternotomy, explantation of the prior 23 mm Magna tissue aortic valve, and aortic valve replacement with a 23 mm Edwards Inspiris Resilia aortic valve.

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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, 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

---

Frequency: once weekly

PCP: Dr. Nigrelli Grayling f/u 4-6 weeks

Cardiac: Yelevarthy TC heart and vascular f/u9/2 9am

Cardiothoracic surgeons of Grand traverse: f/u 8/24 11am

Upon arrival greeted by pt and spouse on front porch, SOC completed on front porch. Lives with daughter and spouse- 1 dog. Pt states couldn't breathe walked to the mailbox and up to the porch and stated doesn't think he's going to make it. Pts wife took pt to the ER. Admitted Grayling hospital 7/27 transferred to Munson TC 7/29, discharged 8/10. Pt ambulates with cane or walker depending on distance/balance. Open heart surgery new valve placed. Edema BLE pitting +3. VS within normal parameters for pt, assessment completed. Pt states pain 5/10 on chest from bruising/surgery. Pt states is having random few dizzy spells.

- Referral for RN home health services under the Open Heart Pathway following cardiothoracic surgery. The order states that symptoms support difficulty leaving home for required medical services and directs vital sign and weight monitoring.

- The patient was transferred from Grayling ED to Munson Medical Center for acute decompensated heart failure, exertional dyspnea, exertional left anterior chest pain, orthopnea, leg swelling, and atrial flutter. Evaluation showed severe stenosis of the prior bioprosthetic aortic valve and reduced ejection fraction of 35%-40%. On 08/03/2026, he underwent redo sternotomy, explantation of the prior 23 mm Magna tissue aortic valve, and aortic valve replacement with a 23 mm Edwards Inspiris Resilia aortic valve.

SN GOALS
PATIENT-STATED GOAL: heal incision and regain strength

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

patient/caregiver recalls
* how to 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
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* 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/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

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 08/13/2026

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: 08/04/2026	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 **SHELLY SLIVINSKI** 829 N CENTER AVE STE 298 GAYLORD, MI 49735-1683 NPI 1770568248	**Phone Number** (989) 731-7708 **Fax Number** 19897317929

Physician's Signature and Date Signed

X

SHELLY SLIVINSKI, PA-C
08/04/2026: Date of physician last face-to-face