HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195701

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
0077169455	07/22/2026	07/22/2026 - 09/19/2026	821	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Gavin Vanluchene 1599 ESTELLE RD GAYLORD, MI 49735	Male	02/16/1991	(989) 350-7238
	Email		Primary Language: English

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:
inability to leave home without assistance	patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home

ICD-10 CM Principal Diagnosis: K70.40. Alcoholic hepatic failure without coma

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
		CHRONULAC 20 g Oral q1h Midodrine Hydrochloride - Midodrine Hydrochloride 5mg- 3 tabs by mouth three times a day Pantoprazole - Pantoprazole Sodium 40 mg 1 tab by mouth once a day Propanolol - Hydrochlorothiazide: Propranolol Hydrochloride 10 mg by mouth twice a day Thiamine - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 100mg 1 tab by mouth once a day Naltrexone Hydrochloride - Naltrexone Hydrochloride 50 mg 1 tab by mouth once a day Lasix - Furosemide 40mg by mouth once a day Spironolactone - Spironolactone 100 mg 1 tabs by mouth once a day

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 Ambulation, Endurance	**Activities Permitted** Walker, Up As Tolerated, Independent at Home
DME & Supplies walker	**Safety Measures** walker precautions, fall precautions, ambulates with device, ambulates with assistance
Nutrition Z. NO PHYSICIAN-ORDERED DIET	**Allergies** no known allergies

Advance Directives
There are no Advance Care Planning documents on file.

Caregiver Status
0. No assistance needed - patient is independent or does not have needs in this area; 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
add discharge plan

Orders for Discipline and Treatment:
1 - SOC - SN: SN SOC

PT Eval: eval and treat

OT Eval: eval and treat

SN CAREPLAN

SN frequency WK1: 1 (07/22/26-07/25/26),WK2: 1 (07/26/26-08/01/26),WK3: 1 (08/02/26-08/08/26),WK4: 1 (08/09/26-08/15/26),WK5: 1 (08/16/26-08/22/26)

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: 2. Unintentional weight loss of a total of 10 pounds or more 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, 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:There are no Advance Care Planning documents on file.

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, M1400 - Dyspnea, muscle weakness, limited strength, limited endurance

PROCEDURES: cough/deep breathing exercises

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, * strategies to increase caloric intake, 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

SN NARRATIVE

Pt states went into the hospital due to 2 vessels ruptured in throat coughed up a lot of blood. Went into OMH Munson transferred Corwell William Beaumont on 6/30- discharged on 7/16. Pt states no other medical concerns. Pt states has been struggling with alcoholism for 10yrs. Pt states has never been a part of a program or tried to quit. Pt states want to quit started Smart Recovery- online program. Pt lives in Gaylord has own home, currently residing with parents during recovery. PT and OT Eval, pt refuses SN.

- Referral requests home care services at discharge from an inpatient hospitalization.
- The available referral identifies an inpatient general medicine admission beginning 06/30/2026 with alcoholic hepatic failure without coma as the primary diagnosis. No additional hospital course, acute management details, or specific home health treatment orders are included.

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SN GOALS

PATIENT-STATED GOAL: increased strength, live independently, no alcohol

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
* strategies to increase caloric intake
* 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

OT CAREPLAN	OT NARRATIVE
OT PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating	PT is living with mother and abiding by the treatment plans set forth. Activity tolerance is fair+ but is in a weakened condition. He is able to stand and complete all activities of daily living with lots of rest breaks. PT is independent with dressing, grooming and toileting with extra time and is able to bath self in bath tub with extra time. EDU on home safety and falls prevention completed. PT is sleeping well, eating is problematic and he had a recent set back that he was not able to eat for several days because of a new med prescribed. He is now keeping food down and drinking a lot of water. Memory appears to be intact although slow. No LOB demonstrated during eval. PT would benefit from outpatient to build strength and activity tolerance. Possible referral to a recovery program that is local. No further skilled OT services following eval and edu for home safety and referrals --- PT is living with mother after hospitalization but WFL in all ADL's --- PT is living with mother after hospitalization but WFL in all ADL'sPT is living with mother and abiding by the treatment plans set forth. Activity tolerance is fair+ but is in a weakened condition. He is able to stand and complete all activities of daily living with lots of rest breaks. PT is independent with dressing, grooming and toileting with extra time and is able to bath self in bath tub with extra time. EDU on home safety and falls prevention completed. PT is sleeping well, eating is problematic and he had a recent set back that he was not able to eat for several days because of a new med prescribed. He is now keeping food down and drinking a lot of water. Memory appears to be intact although slow. No LOB demonstrated during eval. PT would benefit from outpatient to build strength and activity tolerance. Possible referral to a recovery program that is local. No further skilled OT services following eval and edu for home safety and referrals --- PT is living with mother after hospitalization but WFL in all ADL's

PT CAREPLAN
PT

PROBLEMS IDENTIFIED ON ASSESSMENT: GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, 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

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 NARRATIVE
Pt states went into the hospital due to 2 vessels ruptured in throat coughed up a lot of blood. Went into OMH Munson transferred Corwell William Beaumont on 6/30- discharged on 7/16. Pt states no other medical concerns. - Referral requests home care services at discharge from an inpatient hospitalization. Patient reports he came home with a 2ww and only used it for 2 days and hasn't needed it since. He denies pain. He reports he is getting around just fine and feels good today.
At this time patient is physically capable of moving throughout the home without any assist or AD, balance is good, strength is good and he is independent with ADL's. PT advised patient to go for walks to improve endurance within tolerance and continue to stay active to return to PLOF. Patient is not working at this time but when he returns to work he has a labor strenuous job. PT advised patient in easing back into the job duties to avoid injury. At this time he does not require skilled PT interventions.

Pt states went into the hospital due to 2 vessels ruptured in throat coughed up a lot of blood. Went into OMH Munson transferred Corwell William Beaumont on 6/30- discharged on 7/16. Pt states no other medical concerns. - Referral requests home care services at discharge from an inpatient hospitalization

Patient is independent with functional mobility and ADL's at this time, No further PT is needed at this time

PT GOALS
PATIENT-STATED GOAL: add patient-stated goal

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Sit to Stand - 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

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: KENDRA CHURCHES SN RN on 07/22/2026

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.

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 **Nader Mina**
3535 WEST 13 MILE ROAD SUITE 344
royal oak, MI 48073
NPI 1295997542

Phone Number (248) 551-0497

Fax Number 12485514556

Physician's Signature and Date Signed

X

Nader Mina, MD
: Date of physician last face-to-face