HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195869

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
133829123	06/18/2026	08/17/2026 - 10/15/2026	755	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Shelly Gyles 200 TOEPHER DR APT 1 HOUGHTON LAKE, MI 48629	Female	01/16/1975	(231) 433-9203
	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:
PATIENT IN NEED OF HOME HEALTH TO COME IN AND ASSIST WITH WOUND CARE AND DAILY ADLS. EVERGREEN HOME HEALTH. THIS IS AN URGENT REFERRAL. PATIENT HAS WEEPING WOUNDS ON LEGS AND LYMPHEDEMA, OPEN WOUND ON RIGHT HEEL.	Need for assistance at home and no other household member able to render care

ICD-10 CM Principal Diagnosis: S91.301D. Unspecified open wound right foot subsequent encounter

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
I89.0	Lymphedema not elsewhere classified	Zofran - Ondansetron Hydrochloride 4 MG / 1 TABLET by mouth every 8 hours Tylenol with Codeine #3 Oral Tablet 300-30 MG 1 tablet by mouth once a day Sumatriptan Succinate - Sumatriptan Succinate 100 mg 0.5 - 1 TABLET by mouth as necessary once a day as needed for migraine Simvastatin - Simvastatin 40 mg 1 tablet by mouth at bedtime Risperidone - Risperidone 1 mg 4 tablets by mouth at bedtime QUEtiapine Fumarate Oral Tablet 300 MG 1 tablet by mouth at bedtime QC Acetaminophen 8Hr Arth Pain Oral Tablet Extended Release 650 MG 2 tablets by mouth as necessary every 8 hours as needed for pain Propranolol HCl Oral Capsule Extended Release 120 MG 1 capsule by mouth once a day Mirtazapine - Mirtazapine 30 mg 1 tablet by mouth at bedtime Metformin Hcl - Metformin Hydrochloride 1000 MG / 1 tablet by mouth twice a day Meclizine Hydrochloride - Meclizine Hydrochloride 25 mg / 1 tablet by mouth once a day frequency unavailable, used once a day as default, taken about 1 hour before travel; effect lasts up to 24 hours Lyrica - Pregabalin 100 mg 1 capsule by mouth three times a day Losartan Potassium - Losartan Potassium 25 mg 0.5 tablet by mouth once a day Lasix Oral Tablet 20 MG 1 tablet by mouth twice a day Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML 34 UNITS subcutaneous at bedtime Lamictal - Lamotrigine 100 mg 1 tablet by mouth once a day Ibuprofen Oral Tablet 600 MG 1 tablet by mouth every 8 hours hydrOXYzine Pamoate Oral Capsule 50 MG 1 capsule by mouth three times a day HumaLOG KwikPen Subcutaneous Solution Pen-injector 100 UNIT/M 100 UNIT/M subcutaneous three times a day frequency unavailable, used three times a day as default, low sliding scale, please verify GNP Diclofenac Sodium External Gel 1 % 4 GRAMS transdermal four times a day Glipizide - Glipizide 5 mg 1 tablet by mouth once a day Flonase Allergy Relief Nasal Suspension 50 MCG/ACT 1 spray EACH NOSTRIL inhalant twice a day
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	
E11.65	Type 2 diabetes mellitus with hyperglycemia	
I87.2	Venous insufficiency (chronic) (peripheral)	
E66.01	Morbid (severe) obesity due to excess calories	
I26.99	Other pulmonary embolism without acute cor pulmonale	

E03.9	Hypothyroidism unspecified	spray EACH NOSTRIL inhalant twice a day Eliquis Oral Tablet 5 MG 1 tablet by mouth twice a day ECK Ferrous Sulfate Oral Tablet 325 (65 Fe) MG 1 tablet by mouth every other day CVS Omeprazole Magnesium Oral Capsule Delayed Release 20 MG 20 mg / 1 capsule by mouth once a day before breakfast (frequency unavailable, used once a day before breakfast as default Clotrimazole-Betamethasone External Cream 0.05-1 % 1 application topical twice a day Benztropine Mesylate - Benztropine Mesylate 1 mg 1 tablet by mouth twice a day Allergy (Cetirizine) Oral Tablet 10 MG 1 tablet by mouth as necessary once a day as needed for allergy Albuterol Inhalation Aerosol Solution 90 MCG/ACT 2 puffs inhalant every 4 hours
D64.9	Anemia unspecified	

Prognosis fair	**Mental and Psychosocial Status** COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:
Functional Limitations Dyspnea With Minimal Exertion, Ambulation, Endurance	**Activities Permitted** Walker, Up As Tolerated
DME & Supplies walker, bath bench, grab bars, wound care supplies, diabetic supplies	**Safety Measures** ambulates with device, walker precautions, medication safety, bleeding precautions, anticoagulant precautions, diabetic precautions, bathroom safety, , fall precautions, Universal/infection precautions, Proper use of assistive devices, Keep pathways clear
Nutrition diabetic,	**Allergies** penicillin (has tolerated unasyn), aspirin (SWELLING OF THROAT; FACIA; SWELLING)

Advance Directives	Caregiver Status
No Advance Directive	1. Non-agency caregiver(s) currently provide assistance
Rehabilitation Potential	**DISCHARGE PLAN:**
SELF-CARE: , MOBILITY:	patient will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - SN

4 - Recertification

4 - Recertification SN

PT Eval

SN CAREPLAN

SN frequency WK1: 2 (08/17/26-08/22/26),WK2: 2 (08/23/26-08/29/26),WK3: 2 (08/30/26-09/05/26),WK4: 2 (09/06/26-09/12/26),WK5: 2 (09/13/26-09/19/26),WK6: 2 (09/20/26-09/26/26),WK7: 2 (09/27/26-10/03/26),WK8: 2 (10/04/26-10/10/26),WK9: 1 (10/11/26-10/15/26)

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: 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

08/25/2026 Problems : #1 - Observable Stasis Ulcer - Anterior Right Below Knee -
#2 - - Posterior Right Thigh -
M1720 - Anxiety
M1610 - Urinary Incontinence
swelling in the arms/legs
balance deficit
open sores/lesions
limited endurance
abnormal BS < 70/140 > mg/dL

PROCEDURES: physician-ordered wound care: #1 - Observable Stasis Ulcer - Anterior Right Below Knee -: Twice weekly: remove old bandage. Cleanse area with wound cleanser or saline. Apply two layer unna boot compression system to RLE., apply compression bandage, physician-ordered wound care: Posterior right thigh pressure ulcer: Remove old dressing. Cleanse wound with saline or wound cleanser. Apply skin prep to edges. Apply silicone foam. Secure with hypafix/retention tape. Twice weekly., glucose testing via monitor, 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, * bowel incontinence management including dietary changes

SN NARRATIVE

Recert assessment completed. Patient agreeable with continued POC with twice weekly visits for wound care to RLE.

RN knocked and entered through unlocked front door. Patient greeted RN in living room. Head to toe assessment completed and vitals obtained. Vitals stable. Wound care performed per order to RLE. Patient agreeable with continued POC. Patient denied further questions or concerns at conclusion of visit.

SN GOALS

PATIENT-STATED GOAL: (In patient's Own Words): heal wounds and decrease leg swelling

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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin 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/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
* strategies to increase socialization
* 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

bowel training skin 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, * strategies to increase socialization, related medication(s) purpose, schedule	

	PT NARRATIVE Pt presents with deficits in BLE strength, gait, ability to perform ADLs, verbal statement of pain, SOB, standing tolerance, walking tolerance and function. Pt ambulates with use of rollator walker, decreased gait speed, FF trunk. Pt able to walk 15 feet today in which pt stated SOB and o2 was monitored and went to 80%. Pt is following up with physician today and PT walked patient to car in which in 15 ft her o2 dropped to 79%. Pt advised to speak with PCP today about o2. Pt will benefit from skilled PT to improve ability to perform ADLs and walking tolerance. Pt reports that she does do seated exercises every few days at home. Pt reports that she has been using a walker for the past month. Pt reports that prior to that she was using a cane outside of home. ---------- 1 wk 8 Pt presents with deficits in BLE strength, gait, ability to perform ADLs, verbal statement of pain, SOB, standing tolerance, walking tolerance and function. Pt ambulates with use of rollator walker, decreased gait speed, FF trunk. Pt able to walk 15 feet today in which pt stated SOB and o2 was monitored and went to 80%. Pt is following up with physician today and PT walked patient to car in which in 15 ft her o2 dropped to 79%. Pt advised to speak with PCP today about o2. Pt will benefit from skilled PT to improve ability to perform ADLs and walking tolerance.

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: KENDRA CHURCHES SN RN on 08/14/2026

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: 05/14/2026	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 **DARCIE DOHNAL** 14734 PARK AVENUE BLDG A CHARLEVOIX PRIMARY CARE CHARLEVOIX, MI 49720-1927 NPI 1487800959	**Phone Number** (231) 547-6554 **Fax Number** 12313927332

Physician's Signature and Date Signed

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DARCIE DOHNAL, MD
05/14/2026: Date of physician last face-to-face