HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195940

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
3JC5RV5GK88	07/24/2026	07/24/2026 - 09/21/2026	845	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
William Herbert 3640 LONG RAPIDS RD ALPENA, MI 49707	Male	05/21/1949	989-354-5655
	Email jackie45h1@yahoo.com		**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:
I639 - Cerebral infarction, unspecified (Acute CVA)	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.

ICD-10 CM Principal Diagnosis: D59.6. Hemoglobinuria due to hemolysis from other external causes

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
I63.9	Cerebral infarction unspecified	TYLENOL 650 mg oral q6h PRN ZYLOPRIM 300 mg oral Daily (0900) MAALOX 40 MG mL oral q4h PRN ASPIRIN 81 mg oral Daily (0900) LIPITOR 10 mg oral Nightly DULCOLAX 10 mg rectal Daily PRN COLACE 100 mg oral BID ZESTRIL 10 mg oral Daily (0900) ZESTORETIC oral Daily (0900) [Held by provider] MAGNESIUM 400 MG mL oral Daily PRN MELATONIN 6 mg oral Nightly PRN PROTONIX 20 mg oral Daily AC MIRALAX 17 g oral Daily PRN MESTINON 60 mg oral TID semaglutide (weight loss) (Wegovy) injection 2.4 mg subcutaneous Weekly START ON 7/23/2026 ACETAZOLAMIDE SODIUM 10 mL intravenous PRN FLOMAX 0.4 mg oral Nightly DETROL 4 mg oral Daily (0900)
Z79.899	Other long term (current) drug therapy	
E66.9	Obesity unspecified	
G47.33	Obstructive sleep apnea (adult) (pediatric)	
K21.9	Gastro-esophageal reflux disease without esophagitis	
E16.2	Hypoglycemia unspecified	
I10.	Essential (primary) hypertension	
E78.5	Hyperlipidemia unspecified	
D69.6	Thrombocytopenia unspecified	
D64.9	Anemia unspecified	
N40.1	Benign prostatic hyperplasia with lower urinary tract symp	
R32.	Unspecified urinary incontinence	
R47.81	Slurred speech	
Z47.89	Encounter for other orthopedic aftercare	
G73.1	Lambert-Eaton syndrome in neoplastic disease	
M48.02	Spinal stenosis cervical region	

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 Speech, Ambulation	**Activities Permitted** Walker
DME & Supplies 4 wheeled walker, walker	**Safety Measures** fall precautions, walker precautions
Nutrition regular, cardiac diet	**Allergies** no known allergies

Advance Directives	Caregiver Status
full code	1. Non-agency caregiver(s) currently provide assistance; 1. Non-agency caregiver(s) currently provide assistance
Rehabilitation Potential	**DISCHARGE PLAN:**
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.	family/caregiver will be responsible for managing treatment patient will be responsible for managing treatment family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - SN

PT Eval

OT Eval

4 - Recertification

4 - Recertification PT

SN CAREPLAN

SN frequency WK1: 1 (07/24/26-07/25/26),WK2: 1 (07/26/26-08/01/26),WK3: 1 (08/02/26-08/08/26),WK5: 1 (08/16/26-08/22/26),WK7: 1 (08/30/26-09/05/26),WK9: 1 (09/13/26-09/19/26)

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: 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

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.; Strengthen Educate on ambulation and fall risk
Advance Directive:full code

07/28/2026 Problems : Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
impaired speech
muscle weakness
frequent urination
increased urine output
bruising/discoloration
B1000 - Vision Deficit

PROCEDURES: Speech: speech to eval and treat, Blood pressure : blood pressure education and monitoring, cough/deep breathing exercises, incentive spirometer, physician-ordered wound care, wound vacuum, bladder training, coordinate/arrange resources for vision-impaired

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

SN NARRATIVE

Patient is being admitted today for SN, PT, OT, and Speech Patient was greeted upon arrival
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Patient lives with his wife how helps with daily cares and patient is SBA with ambulation around the home.

Patient has a PMH of multiple strokes, including remote subarachnoid hemorrhage/subdural hematoma dated 01/28/2018 and chronic left thalamic lacunar infarct.
- Acute right posterior limb internal capsule/adjacent white matter infarct with dysarthria, weakness, gait impairment, and impaired ADLs.
- Lambert-Eaton myasthenic syndrome; MuSK antibody positive; outpatient IVIG currently on hold; follows neurology in Traverse City.
- Intracranial vascular disease, marked cerebral atrophy, prominent cerebral small-vessel disease, and multiple hemosiderin/susceptibility deposits.
- Hypertension, coronary artery disease, hyperlipidemia, obstructive sleep apnea with home CPAP, GERD, BPH, overactive bladder/urinary incontinence, cervical spinal stenosis, lumbosacral facet degeneration, left shoulder osteoarthritis/rotator cuff arthropathy, gout, anemia, mild thrombocytopenia, mild hyponatremia, and class II obesity.

Patient and his wife were greeted upon arrival. Patient was sitting in hos chair in the Livingroom when I arrived. SOC paperwork was completed along with vitals and assessment. Vitals were all within normal parameters for this patient. Upon assessment patient did have some aphagia. Patient and his wife were educated on the importance of patient getting up and ambulating to help decrease risk of worsening muscle weakness and skin breakdown. Patient and wife stated understanding of education. Patient and wife were informed of future PT and OT eval visits and stated no further questions or needs upon completion of visit.

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- Hypertension, coronary artery disease, hyperlipidemia, obstructive sleep apnea with home CPAP, GERD, BPH, overactive bladder/urinary incontinence, cervical spinal stenosis, lumbosacral facet degeneration, left

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

shoulder osteoarthritis/rotator cuff arthropathy, gout, anemia, mild thrombocytopenia, mild hyponatremia, and class II obesity.

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SN GOALS
PATIENT-STATED GOAL: work on strength and speech

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 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

OT CAREPLAN
OT frequency WK3: 1 (08/02/26-08/08/26),WK4: 1 (08/09/26-08/15/26),WK5: 1 (08/16/26-08/22/26),WK6: 1 (08/23/26-08/29/26)

08/04/2026 Problems : GG0130B1 - Oral Hygiene
GG0130F1 - Upper Body Dressing
GG0130G1 - Lower Body Dressing
GG0130H1 - Don/Doff Footwear
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130A1 - Eating

PROCEDURES: TRANSFER TRAINING: TRANSFER TRAINING, NEURO MUSCULAR RE-EDUCATION: NEURO MUSCULAR RE-EDUCATION, cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation

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, Oral Hygiene - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent, Upper Body Dressing - 06. Independent, PATIENT WILL DEMONSTRATE IMPROVED BUE STRENGTH NECESSARY FOR ADL/IADLS, TRANSFERS AND BED MOBILITY., PATIENT WILL IMPROVE LEFT HAND STRENGTH AND COORDINATION FOR IMPROVED TASKS SUCH AS CUTTING FOOD, PATIENT WILL UTILIZE INSTRUCTED TECHNIQUES FOR IMPROVED FALL SAFETY WITH ADL'S AND MOBILITY AS SEEN WITH IMPROVED EMS SCORE TO 10/20..

OT NARRATIVE
OT reassessment completed this date. Patient has progressed with skilled OT intervention as evidenced by improved transfers to SBA and improved L elbow and grip strength to 45#. He reports improved LB dressing, but declines practicing. He likely requires SBA due requiring SBA for transfers. Writer progressed LUE strengthening HEPS with red theraband for resistance. Plan to continue OT POC and discharge end of episode due to patient progression.

OT GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

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

Oral Hygiene - 06. Independent

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

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

Eating - 06. Independent

Upper Body Dressing - 06. Independent

PATIENT WILL DEMONSTRATE IMPROVED BUE STRENGTH NECESSARY FOR ADL/IADLS, TRANSFERS AND BED MOBILITY.

PATIENT WILL IMPROVE LEFT HAND STRENGTH AND COORDINATION FOR IMPROVED TASKS SUCH AS CUTTING FOOD

PATIENT WILL UTILIZE INSTRUCTED TECHNIQUES FOR IMPROVED FALL SAFETY WITH ADL'S AND MOBILITY AS SEEN WITH IMPROVED EMS SCORE TO 10/20..

Toileting Hygiene - 05. Setup or clean-up assistance

PT CAREPLAN	PT NARRATIVE
PT frequency 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),WK6: 1 (08/23/26-08/29/26),WK7: 1 (08/30/26-09/05/26),WK8: 1 (09/06/26-09/12/26) 08/24/2026 Problems : 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	As of 30 day reassessment, the patient continues make progress toward functional goals, participates in care, and tolerated PT interventions well at today's visit. Pain with ambulation and balance deficits still bother patient. Ptnt educated HEP strength exercises held due to BP elevated. Balance training performed to decreased risk of falls, with patient balancing for a total of 30 seconds x each of feet together with eyes open, feet in tandem stance with eyes open R foot in front of L for one set, then L in front of R for the next set. with one hand on kitchen sink/counter. Written instructions provided for use as part of home exercise program, with written reminder for safety by having upper extremities ready at the sink/counter in case of a loss of balance. Functional test performed: 66 sec on TUG as baseline test, will continue to monitor. Ambulation performed with patient ambulating a distance of 50 ft feet in three attempts, using rolling walker for safety. Ptnt observed having difficulty with 180 degree turn keeping feet inside walker. The patient would continue to benefit from continued physical therapy services in order promote greater independence and decrease risk of falls and further hospitalizations. Plan for future visits is to progress therapeutic exercises, transfer and gait training and to update home exercise program. Patient and caregiver to be educated on progress made and realistic goals for PT. Progress has been slowed by medical comorbidities and safety concerns.

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 07/24/2026

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 **BRANDON WHITSCELL** 1185 U.S. 23 N ALPENA, MI 49707-0857 NPI 1932304862	**Phone Number** (989) 356-4049 **Fax Number** 19893583712

Physician's Signature and Date Signed

X

BRANDON WHITSCELL, PA-C
: Date of physician last face-to-face