HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195820

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
H73620792	08/12/2026	08/12/2026 - 10/10/2026	894	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Cheryl Boling 367 PENN RD MIO, MI 48647	Female	04/18/1958	(810) 813-5846
	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:
- Home care referral ordered for RN and Physical Therapy after left total knee arthroplasty (L TKA). The order documents symptoms supporting difficulty leaving home for required medical services,	Symptoms identified support difficulty to leave home for medical services required.

ICD-10 CM Principal Diagnosis: Z47.1. Aftercare following joint replacement surgery

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
Z96.652	Presence of left artificial knee joint	otcefdroxil 500 mg oral capsule 500 MG mg=1 Oral q12hr CITRACAL 250 MG Tab Chew qAM LOSARTAN POTASSIUM 25 MG mg= 1 Tab Oral Daily 1 refill OMEPRAZOLE 20 MG mg= 1 Cap Oral Daily 3 refills OXYCODONE 5 MG Tabs Oral q4hr PRN PEPCID 20 MG mg= 1 Tab Oral BID SENNA 50 MG Tab Oral Daily SUPER B COMPLEX 1 Tab Oral QHS TYLENOL 500 MG mg= 2 Tab Oral q8hr WARFARIN 5 MG Tab Oral Daily 3 refills
M17.12	Unilateral primary osteoarthritis left knee	
M25.562	Pain in left knee	
I10.	Essential (primary) hypertension	
Z86.718	Personal history of other venous thrombosis and embolism	
Z86.711	Personal history of pulmonary embolism	
D68.69	Other thrombophilia	
G47.33	Obstructive sleep apnea (adult) (pediatric)	

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 Endurance, Ambulation	**Activities Permitted** Walker, Up As Tolerated
DME & Supplies rolling walker, bath bench	**Safety Measures** walker precautions, infectious material management, fall precautions, bleeding precautions, ambulates with device, knee precautions, bathroom safety, anticoagulant precautions
Nutrition regular	**Allergies** CeleBREX - Palpitations, diphtheria-tetanus toxoids (obsolete) - Anaphylactic reaction, Eliquis - ineffective drug action, tetanus toxoids - Anaphylaxis

Advance Directives
Living Will

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
patient will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

PT Eval

SN CAREPLAN

SN frequency WK1: 1 (08/12/26-08/15/26)

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

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:Living Will

08/25/2026 Problems : #1 - Non-Observable Surgical Wound - Anterior Left Knee - Not observable, non removable dressing.
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
dependent edema
limited strength
limited endurance
bruising/discoloration

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Left Knee - Not observable, non removable dressing.: non-removable dressing on until f/u with surgeon

TEACH PATIENT/CAREGIVER: * 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule

SN NARRATIVE

Frequency: Only requesting PT, discharge from SN refused service-requesting PT at earliest time possible
PCP: Stephanie Rutterbush states new doc took over in Lewiston soon will not be Rutterbush she is moving to petoskey unsure of doc whos taking over name.
Surgeon: Michael Vanwagner

Pt went into TC Munson on August 4th pt discharged August 7th, stayed a few days for pain management due to L TKA. Pt lives with husband, one dog. Very supportive husband and neighbors. Pt states pain is tolerable 8/10 pt states just got dressed and showered, when just resting/sitting sits at a 3/10. Pt states checks warfarin once weekly- today was 2.6. F/u appt on 8/19. No other concerns at this time.

- Primary Diagnosis: Z471 - Aftercare following joint replacement surgery
Source: Operative report and home care referral document left total knee arthroplasty on 08/04/2026 with home health referral after surgery
Rationale: Chosen as the PDGM-eligible surgical aftercare diagnosis most directly aligned with the current home health episode after left total knee replacement.

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SN GOALS

PATIENT-STATED GOAL: pts states incision will heal, increased mobility/strength from knee replacement

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

PT CAREPLAN

PT frequency WK1: 1 (08/12/26-08/15/26),WK2: 2 (08/16/26-08/22/26),WK3: 2 (08/23/26-08/29/26),WK4: 2 (08/30/26-09/05/26),WK5: 2 (09/06/26-09/12/26)

08/14/2026 Problems : GG0170G1 - Car Transfer
GG0170P1 - Picking Up Object
GG0170O1 - 12 Steps
GG0170N1 - 4 Steps
GG0170M1 - 1 - Step (curb)
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170K1 - Walk 150 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170I1 - Walk 10 Feet
GG0130B1 - Oral Hygiene
GG0170E1 - Chair to Bed to Chair
GG0170D1 - Sit to Stand
GG0130C1 - Toileting Hygiene
GG0170F1 - Toilet Transfer
GG0130E1 - Shower/Bathe Self
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130F1 - Upper Body Dressing

PROCEDURES: home exercise program: Instruct and progress HEP as tolerated for post operative TKA. Including seated, supine and standing activities, NMR, ther ex, ther activity, equipment training, work simplification/energy conservation, gait training/stair training, neuromuscular re-education: Dynamic balance training exercise, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car 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, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT NARRATIVE

S/P L TKA on 8/4/26, Hx of RTKA 12/2025, R THA 01/2022. Patient reports she has been doing well with ice and pain medication.
PATIENT PRESENTS WITH SIGNS AND SYMPTOMS CONSISTENT WITH L KNEE PAIN FOLLOWING L TKA ON 08/4/2026.
PT EXAMINATION REVEALS: GENERALIZED WEAKNESS, BALANCE AND GAIT DEFICITS, L LE MOBILITY AND STABILITY LIMITATIONS, POOR COORDINATION AND SAFETY IN THE HOME AND IS A FALL RISK. THESE LIMITATIONS ARE AFFECTING THEIR ADL FUNCTION AND FUNCTIONAL ABILITY TO AMBULATE IN THE HOME, PAIN WITH SIT TO SUPINE TRANSFERS, DIFFICULTY WITH STAIR NEGOTIATION, DIFFICULTY WITH SIT TO STAND TRANSFERS, TRANSFERING IN AND OUT OF THE SHOWER, AND DIFFICULTY SLEEPING.
PATIENT HAS NOT BEEN PERFORMING KNEE FLEXION EXERCISES AND HAS BEEN ICING CONSTANTLY THROUGHOUT THE DAY. PT ADVISED PATIENT TO REDUCE THE FREQUENCY OF ICING AND INCREASE MOVEMENT AND HEP ACTIVITY. INSTUCTED INITAL HEP TO INCLUDE SEATED HEEL SLIDES, ELEVATED ANKLE PUMPS, QUAD SETS, GLUT SETS, AND SUPINE OR RECLINED HEEL SLIDES WITH STRAP TO ASSIST.
PLOF: PATIENT WAS PREVIOUSLY INDEPENDENT IN THE HOME.
AT THIS TIME PATIENT REQUIRES SKILLED PT TO ADDRESS THE AFORMENTIONED LIMITATIONS AND IMPROVE FUNCTION TO BE ABLE TO RETURN TO PLOF IN THE HOME AND COMMUNITY.

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PT EXAMINATION REVEALS: GENERALIZED WEAKNESS, BALANCE AND GAIT DEFICITS, L LE MOBILITY AND STABILITY LIMITATIONS, POOR COORDINATION AND SAFETY IN THE HOME AND IS A FALL RISK. THESE LIMITATIONS ARE AFFECTING THEIR ADL FUNCTION AND FUNCTIONAL ABILITY TO AMBULATE IN THE HOME, PAIN WITH SIT TO SUPINE TRANSFERS, DIFFICULTY WITH STAIR NEGOTIATION, DIFFICULTY WITH SIT TO STAND TRANSFERS, TRANSFERING IN AND OUT OF THE SHOWER, AND DIFFICULTY SLEEPING.

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PT GOALS

PATIENT-STATED GOAL: Complete in home rehab

GOALS
Toilet Transfer - 06. Independent

Car Transfer - 06. Independent

Picking Up Object - 04. Supervision or touching 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

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

Sit to Stand - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 08/12/2026

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: 08/07/2026	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 **STEPHANIE RUTTERBUSH** 1619 ANDERSON ROAD PETOSKEY, MI 49770 NPI 1649652298	**Phone Number** (231) 417-6010 **Fax Number** (231) 417-6005
Physician's Signature and Date Signed **X** **STEPHANIE RUTTERBUSH, MD** 08/07/2026: Date of physician last face-to-face	