HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195587

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
5XG1PU1PK92	06/08/2026	08/07/2026 - 10/05/2026	715	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
DOLORES SMILOWSKI 1130 SHADOW LN GAYLORD, MI 49735	Female	10/05/1939	(989) 448-8281
	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:
Alzheimer's disease with late onset	Residual weakness, There exists a normal inability to leave the home. Leaving home requires a considerable and taxing effort, because of illness or injury,

ICD-10 CM Principal Diagnosis: G30.1. Alzheimer's disease with late onset

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
R26.89	Other abnormalities of gait and mobility	Atorvastatin Calcium - Atorvastatin Calcium 20 mg / 1 Tablet by mouth once a day Hydrochlorothiazide - Hydrochlorothiazide 12.5 mg / 1 tablet by mouth once a day Lisinopril - Lisinopril 10 mg / 1 Tablet by mouth once a day Metformin Hcl - Metformin Hydrochloride 500 mg / 1 tablet - 2 tablets by mouth twice a day Mirtazapine - Mirtazapine 7.5 mg / 1 tablet by mouth at bedtime
F02.80	Dem in oth dis classd elswhrunsp sevw/o beh/psych/mood/anx	
E11.65	Type 2 diabetes mellitus with hyperglycemia	
E11.3293	Type 2 diab with mild nonp rtnop without macular edema bi	
I10.	Essential (primary) hypertension	
E78.5	Hyperlipidemia unspecified	
D50.0	Iron deficiency anemia secondary to blood loss (chronic)	
R63.4	Abnormal weight loss	

Prognosis	Mental and Psychosocial Status
good	COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: 2. On awakening or at night only, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:
Functional Limitations Ambulation	**Activities Permitted** Walker, Up As Tolerated, Independent at Home
DME & Supplies bath bench, 4 wheeled walker	**Safety Measures** diabetic precautions, fall precautions, , walker precautions, , ambulates with device,
Nutrition diabetic	**Allergies** NKDA

Advance Directives	Caregiver Status
Living Will	0. No assistance needed - patient is independent or does not have needs in this area
Rehabilitation Potential	**DISCHARGE PLAN:**
SELF-CARE: , MOBILITY:	family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - SN: Alzheimer's disease with late onset

4 - Recertification

PT Eval

SN CAREPLAN

SN frequency WK2: 1 (08/09/26-08/15/26),WK3: 1 (08/16/26-08/22/26),WK4: 1 (08/23/26-08/29/26),WK5: 1 (08/30/26-09/05/26),WK6: 1 (09/06/26-09/12/26),WK7: 1 (09/13/26-09/19/26),WK8: 1 (09/20/26-09/26/26),WK9: 1 (09/27/26-10/03/26)

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

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

PROCEDURES: Assess Cognition and ability to live independently at every visit: Pt has Alzheimers, report any changes in cognition or safety to self/others, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion, glucose testing via monitor: Pt does not check or monitor BS, is on oral meds.

SN NARRATIVE

Upon arrival greeted by pt and her son who was present for Recert. Pts son states he would like to receive all documentation from every visit in spruce to be able to see how his moms progress is going. No concerns. Pts son states pts strength is not great and wants PT back, RN will message Kaitlin and relay to pts son reason for discharge and look into PT reassessing pt. Pts son states short term memory is not great, but pt is still able to live independently, still recognizes everyone alert and oriented at recert.

SN GOALS

PATIENT-STATED GOAL: Pt states increase strength with PT.

GOALS

	PT NARRATIVE Patient was referred for PT evaluation due worsening gait and balance, and reduced activity. Patient was previously seen for PT and worked on training with AD however she refuses to use it on her own. She reports she has not had any falls, she denies pain, and reports being independent with all ADL's, dressing, grooming and bathing activities. Patient presents with balance deficits tinetti 22/28 indicating moderate fall risk. She has a cane and a walker but states she doesn't need them and doesn't use them when she is on her own. She states when people come visit they ask her to use the cane and she will to appease them but as soon as they leave she is not using the AD. She is currently living independently and demonstrates good ability to perform transfers with UE support, transferring in and out of the shower independently. She has a shower chair but does not use it, stating it isn't hers and she doesn't need it. Patient has mild strengthen deficits as expected for her age. Patient continues to report that she feels strong and doesn't need to do exercises. PT educated patient on need for some maintenance therapy to maintain balance and BLE strength. Patient has some limitations with L shoulder ROM and strength, possible RTC damage but is able to functionally reach her hair and wash under the arms. Patient will benefit from further skilled PT interventions to address balance deficits and maintain B LE strength. PT will continue to encourage use of cane or walker for ambulation however carryover may be limited as with previous episode of care. PT will also review and progress HEP however carryover may also be limited due to patient compliance and dementia. Stating she is doing just fine and is strong for her age.

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAVANNAH GRANDCHAMP SN RN on 08/03/2026

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 **STEVEN WISNIEWSKI** 829 N CENTER AVE SUITE 140 GAYLORD, MI 49735-1595 NPI 1104851658	**Phone Number** (989) 731-7870 **Fax Number** 19897317837

Physician's Signature and Date Signed

X

STEVEN WISNIEWSKI, MD
: Date of physician last face-to-face