HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195915

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
H55117699	08/10/2026	08/10/2026 - 10/08/2026	881	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Diane Jullette 1821 EAST STATE ST CHEBOYGAN, MI 49721	Female	02/02/1968	(231)818-0121
	Email BUBANDDI@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:
- Referral follows hospitalization beginning 07/31/2026 for weakness with three days of nausea/vomiting/diarrhea and redness of the left leg/left heel wound. The hospital course included cardiac evaluation and treatment, management of reduced ejection fraction, diabetes, and evaluation of left heel redness/ulcer. - Recent notes document coronary artery disease, congestive heart failure with EF 25-30%, atrial fibrillation, chronic kidney disease stage 3, hypertension, hyperlipidemia, type 2 diabetes with neuropathy/hyperglycemia, chronic pain, prior CVA, MRSA history, prior right foot osteomyelitis/amputations, and a left heel ulcer. Orthopedic consultation documented left leg redness and an ulcer of unknown severity on the left heel.	patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home, medical condition could get worse if patient leaves home

ICD-10 CM Principal Diagnosis: E11.621. Type 2 diabetes mellitus with foot ulcer

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
L97.429	Non-prs chronic ulcer of left heel and midfoot w unsp severt	ASPIRIN 81 mg, 1 tabs Oral Daily ATORVASTATIN 80 mg, 1 tabs Oral Daily ALCOHOL 10% AND DEXTROSE 5% 25 g, 50 mL IV Push Unscheduled, PRN FUROSEMIDE 40 mg, 1 tabs Oral Daily GABAPENTIN 800 mg, 2 cap Oral BID PLAVIX 75 mg, 1 tabs Oral Daily FAMOTIDINE 20 mg, 1 tabs Oral Daily IMODIUM 2 mg, 1 cap Oral Q2H, PRN
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	
I50.22	Chronic systolic (congestive) heart failure	
I48.0	Paroxysmal atrial fibrillation	
E11.65	Type 2 diabetes mellitus with hyperglycemia	
N18.30	Chronic kidney disease stage 3 unspecified	
I10.	Essential (primary) hypertension	

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: Yes
Functional Limitations R BKA	**Activities Permitted** Wheelchair
DME & Supplies wheelchair	**Safety Measures** fall precautions, wheelchair precautions, anticoagulant precautions
Nutrition cardiac diet	**Allergies** iodine (Anaphylaxis), Adhesive Bandage (redness to skin, itching and burning), Norco (Nausea and vomiting), shellfish (Throat tightness), codeine (Unknown), Bee Stings (Throat tightness, Swelling)

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Advance Directives	Caregiver Status
Living Will	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	**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.	patient will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - SN

3 - ROC - SN

SN CAREPLAN

SN frequency WK1: 1 (08/10/26-08/15/26),WK2: 1 (08/16/26-08/22/26),WK3: 1 (08/23/26-08/29/26),WK4: 1 (08/30/26-09/05/26),WK5: 1 (09/06/26-09/12/26),WK6: 1 (09/13/26-09/19/26),WK7: 1 (09/20/26-09/26/26),WK8: 1 (09/27/26-10/03/26),WK9: 1 (10/04/26-10/08/26)

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

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

08/10/2026 Problems : A1250 - Lack of Necessary Transportation
M1610 - Urinary Incontinence
M1400 - Dyspnea
M2020 - Oral Med Management
dependent edema
open sores/lesions
abnormal BS < 70/140 > mg/dL
B1000 - Vision Deficit
D0160 - Depression

PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: Cleans with wound cleanser, Pat dry, apply xeroform to wound bed and wrap with gauze and ace wrap if needed., glucose testing via monitor, monitor intake & output, coordinate/arrange resources for vision-impaired, coordinate/arrange transportation services

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related 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, patient's transportation needs are met

SN NARRATIVE

missed visit

SN GOALS

PATIENT-STATED GOAL: Wounds

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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive 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
* 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

patient's transportation needs are met

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Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 08/10/2026

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 **KATIE FULCHER** 416 CONNABLE AVE P ETOSKEY, MI 49770-2212 NPI 1851705727	**Phone Number** (231) 487-7969 **Fax Number** 12314873063

Physician's Signature and Date Signed

X

KATIE FULCHER, DO
: Date of physician last face-to-face