HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951490

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
80033302700	09/04/2026	09/04/2026 - 11/02/2026	891	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Bernard Kolasa 4018 COUNTY ROAD 489 ONAWAY, MI 49765	Male	04/10/1958	(989) 370-4261
	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:

- Home health nursing and physical therapy were ordered for postoperative care following a scheduled right total knee arthroplasty at OMH with Dr. Lerche on 08/20/2026. Orders include postoperative assessment and education, gait and range-of-motion training, pain and swelling reduction, and monitoring of the surgical dressing and incision. - The orthopedic office note documents debilitating right knee pain for more than 1-2 years, with worsening pain affecting activities of daily living despite activity modification, weight-loss attempts, home exercise, oral anti-inflammatory medication, and prior corticosteroid injection. MRI showed a complex medial meniscus tear with tricompartmental degenerative changes and full-thickness cartilage loss of the medial compartment and patellofemoral joint. The patient elected to proceed with right total knee arthroplasty.

Physician Statement on Homebound Status:

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: M17.11. Unilateral primary osteoarthritis right knee

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
J44.9	Chronic obstructive pulmonary disease unspecified	ALBUTEROL 90 mcg/inh Inhalation aerosol See Instructions BETAMETHASONE ACETATE AND BETAMETHASONE SODIUM PHOSPHATE 0.05% topical cream DOXYCYCLINE 100 mg oral capsule, 100 mg= 1 Cap Oral BID EZETIMIBE 10 mg oral tablet See Instructions, 3 refills Gabapentin - Gabapentin 300 mg by mouth at bedtime HYDROCHLOROTHIAZIDE 12.5 mg oral capsule See Instructions LOSARTAN POTASSIUM 50 mg oral tablet, 1 Tab Oral BID OMEPRAZOLE 20 mg oral delayed release capsule See Instructions, 3 refills AMLODIPINE 5 mg oral tablet, 5 mg= 1 Tab Oral Daily CENTRUM 2 Tab Oral Daily CITALOPRAM 10 mg oral tablet See Instructions CYCLOBENZAPRINE 5 mg oral tablet, 15 mg= 3 Tab Oral Daily 1 refills DICLOFENAC 75 mg oral delayed release tablet, 1 Tab Oral BID Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 mg by mouth every 6 hours PRAVASTATIN 40 mg oral tablet See Instructions AMLODIPINE AND OLMESARTAN MEDOXOMIL See Instructions amphetamine-dextroamphetamine 20 mg oral tablet, 1 Tab Oral Daily
I10.	Essential (primary) hypertension	
E66.01	Morbid (severe) obesity due to excess calories	
F33.0	Major depressive disorder recurrent mild	
K21.9	Gastro-esophageal reflux disease without esophagitis	
E78.5	Hyperlipidemia unspecified	
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	

Prognosis good	**Mental and Psychosocial Status** 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 None of the above	**Activities Permitted** Up As Tolerated
DME & Supplies None of the above	**Safety Measures** None of the above
Nutrition regular	**Allergies** penicillins (Dyspnea, Shortness of breath) sulfa drugs (Dyspnea, Shortness of breath)

Kolasa, Bernard | Cert Period 09/04/26 - 11/02/26

Advance Directives
No Advance Directive

Caregiver Status
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
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:
SN: patient will be responsible for managing treatment
PT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:
SN, PT, OT to eval and treat

SN CAREPLAN

SN frequency WK1: 1 (09/04/26-09/05/26),WK2: 1 (09/06/26-09/12/26),WK3: 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, 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:No Advance Directive

09/04/2026 Problems : M1400 - Dyspnea
M2020 - Oral Med Management
B1000 - Vision Deficit

PROCEDURES: Incision manag: Dressing to stay on until follow up with ortho. Keep area clean and dry and monitor for s/sx of infection, cough/deep breathing exercises, incentive spirometer, 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 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

SN NARRATIVE

Patient is being admitted today for SN, PT, and OT following a RTKA

Patient lives with his wife in a single family home. Patient is independent with Cares and ADLs and is up independently around then home. Patient has a PMH of Advanced right knee osteoarthritis with chronic debilitating pain, swelling, activity limitation, and slight instability.

- MRI dated 03/02/2026 showed complex medial meniscus tear, tricompartmental degenerative changes, and full-thickness cartilage loss in the medial and patellofemoral compartments.

- COPD without exacerbation, essential hypertension, GERD without esophagitis, hyperlipidemia/hypercholesterolemia, history of cerebrovascular accident without residual deficits, major depressive disorder recurrent mild, morbid obesity, narcolepsy, primary insomnia, psoriasis, and polyosteoarthritis are listed in the problem history.

Patient and his wife were greeted upon arrival. Patient met me at the kitchen table for the visit. Vitals and assessment were completed. Vitals were all within normal. Upon assessment patient had a incision to his right knee. No shadowing noted on the dressing. Dressing is to stay on until follow up visit with surgeon. SOC paperwork was completed. Patient and wife were informed of future PT/OT visits. Patient stated no further questions or needs upon completion of visit.

SN GOALS

PATIENT-STATED GOAL: get to out patient therapy

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 self-administers medications as prescribed
* 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

OT CAREPLAN

OT frequency WK2: 1 (09/06/26-09/12/26)

09/09/2026 Problems : Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400
GG0130B1 - Oral Hygiene
GG0130C1 - Toileting Hygiene
GG0130E1 - Shower/Bathe Self
GG0130G1 - Lower Body Dressing
GG0130H1 - Don/Doff Footwear
GG0130A1 - Eating
GG0130F1 - Upper Body Dressing

OT NARRATIVE

Patient is s/p right TKA on 9/3/26 and resides in a single-level home with wife and cat, with stairs and railing required to enter the home. Patient demonstrates bilateral upper-extremity strength and range of motion within normal limits, with no upper-extremity deficits noted that currently limit participation in ADLs or functional transfers. Patient reports modified independence with most self-care tasks and utilizes wife for assistance as needed, primarily with lower-extremity dressing. Patient reports independence with functional transfers, including toilet, shower, recliner, and bed transfers. Patient currently prefers sleeping in recliner due to increased comfort and positioning following surgery.

Patient reports independently transferring into walk-in shower; however, he

	held onto the towel bar throughout showering for stability. Current DME includes walker, raised handicap toilet seat, and reacher. OT recommended shower chair, grab bars at shower entrance and within shower, grab bar adjacent to toilet, and non-slip/grip pads to improve safety and reduce fall risk. Patient was educated on fall prevention and home safety, including maintaining clear and well-lit pathways, removal of throw rugs, caution with varying floor thresholds and small pet, drying off while still inside the shower prior to transferring out, and use of non-slip shower surfaces. Education was provided regarding use of reacher for LB dressing and donning the affected RLE first. Patient was also instructed in core engagement and controlled weight shifting during sit-to-stand and stand-to-sit transfers to improve stability and reduce compensatory movement through the LLE. Patient reports compliance with icing and medication regimen as directed by physician. Large area of bruising is present along the right upper thigh, with patient reporting increased discomfort this date. Patient is scheduled to begin outpatient physical therapy on 9/19/26. At this time, patient is safely completing the majority of ADLs at a modified-independent level and demonstrates ability to advocate for assistance from wife as needed. No additional skilled home health OT visits are indicated at this time. OT evaluation only; no further OT visits scheduled. Patient is in agreement with plan.

PT CAREPLAN
PT frequency WK2: 2 (09/06/26-09/12/26),WK3: 2 (09/13/26-09/19/26)

09/14/2026 Problems : GG0170D1 - Sit to Stand
GG0170F1 - Toilet 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
GG0170G1 - Car Transfer
GG0170E1 - Chair to Bed to Chair

PROCEDURES: home exercise program, therapeutic exercises: POST SURGICAL TKA EXERCISES, gait training on uneven surfaces, gait training/stair training, transfers training, assist with transferring, assist with mobility, assist with seizure precautions prn, assist with infection control, assist with fall prevention, assist with assistive devices prn, assist with O2 safety

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Car Transfer - 05. Setup or clean-up assistance

PT NARRATIVE
S/P right TKA on 9/3/26. Patient reports difficulty sleeping and general discomfort with pain rating 7-9/10. Patient reports he has been having trouble sleeping due to pain and not being able to get comfortable and has been sleeping in the recliner

PT EXAMINATION REVEALS: GENERALIZED WEAKNESS, BALANCE AND GAIT DEFICITS, R 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.

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.

PT GOALS
PATIENT-STATED GOAL: Complete in home post surgical rehab, improve ambulation

GOALS
Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

Sit to Stand - 05. Setup or clean-up assistance

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Car Transfer - 05. Setup or clean-up assistance

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: ALEXIS ABRAHAM SN RN on 09/04/2026

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: 08/20/2026

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 **ERIC LERCHE**
2147 PROFESSIONAL DRIVE
GAYLORD, MI 49735
NPI 1225264005

Phone Number (989) 732-1753

Fax Number 19897311425

Physician's Signature and Date Signed

X

ERIC LERCHE, DO
08/20/2026: Date of physician last face-to-face