HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951510

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
X3L918456603	09/10/2026	09/10/2026 - 11/08/2026	979	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Sharol Lavalle 435 Murner Rd Gaylord, MI 49735	Female	06/15/1936	9894488807
	Email		Primary Language: Unknown

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:
SN(wound care)	Assistance was needed with multiple ADLs Cognitive impairment limited mobility Patient lives in assisted living facility due to chronic conditions

ICD-10 CM Principal Diagnosis: L97.311. Non-prs chronic ulcer of right ankle limited to brkdwn skin

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	Acetaminophen - Acetaminophen 325 mg 1 tab by mouth as necessary PRN pain Benzonatate - Benzonatate 200 mg 1 tab by mouth once a day Carbidopa And Levodopa - Carbidopa: Levodopa 50 mg;200 mg 1 tab by mouth three times a day Gabapentin - Gabapentin 100 mg 1 tab by mouth once a day Loperamide Hydrochloride - Loperamide Hydrochloride 2 mg 0.5 tab by mouth as necessary PRN diarrhea Omeprazole - Omeprazole 20 mg 1 tab by mouth once a day Rosuvastatin Calcium - Rosuvastatin Calcium 10 mg 1 tab by mouth at bedtime Zofran - Ondansetron Hydrochloride eq 4 mg base 1 tab sublingual as necessary PRN nausea Dicyclomine - Dicyclomine Hydrochloride 2.5ml by mouth three times a day Diltiazem - Diltiazem Hydrochloride 120mg 1 cap by mouth once a day Vitamin B12 - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 1000mcg 1 tab by mouth once a day Melatonin - Melatonin 5mg by mouth at bedtime Aspirin - Aspirin 81mg 1 tab by mouth once a day
N18.30	Chronic kidney disease stage 3 unspecified	
F02.80	Dem in oth dis classd elswhrunsp sevw/o beh/psych/mood/anx	
G20.B2	Parkinson's disease with dyskinesia with fluctuations	
I48.0	Paroxysmal atrial fibrillation	
F32.9	Major depressive disorder single episode unspecified	

Prognosis	Mental and Psychosocial Status
fair	COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: Yes
Functional Limitations Endurance, Bowel/Bladder Incontinence, Ambulation, Hearing	**Activities Permitted** Walker, Up As Tolerated
DME & Supplies bath bench, 4 wheeled walker	**Safety Measures** walker precautions, fall precautions, ambulates with device, bathroom safety, anticoagulant precautions
Nutrition regular	**Allergies** Nabumetone, Bactrim, Spironolactone, Meloxicam, Penicillin

Advance Directives
No Advance Directive

Caregiver Status
1. Non-agency caregiver(s) currently provide assistance; 1. Non-agency caregiver(s) currently provide assistance

Rehabilitation Potential
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

DISCHARGE PLAN:
SN: another facility/provider will be responsible for managing treatment

Orders for Discipline and Treatment:
SN to eval and treat

SN CAREPLAN

SN frequency WK1: 1 (09/10/26-09/12/26),WK2: 1 (09/13/26-09/19/26),WK3: 1 (09/20/26-09/26/26),WK4: 1 (09/27/26-10/03/26),WK5: 1 (10/04/26-10/09/26)

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, 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:No Advance Directive

09/15/2026 Problems : #1 - Abrasion - Anterior Right Ankle -
M1700 - Cognition
D0700 - Social Isolation
M1745 - Behavioral Issues
M1610 - Urinary Incontinence
M1620 - Bowel Incontinence
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
dependent edema
balance deficit
muscle weakness
limited strength
limited endurance
bruising/discoloration
abnormal BS < 70/140 > mg/dL
B1000 - Vision Deficit
D0160 - Depression

PROCEDURES: physician-ordered wound care: #1 - Abrasion - Anterior Right Ankle -: Clean with wound cleanser, apply bandaid to wound., bladder training

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 keep home safe for patient with dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance

SN NARRATIVE

Upon arrival pt was in the shower with aide assisting her. RN waited in apartment until completion of shower. Pt had a fall in the shower on 8/31 and had a fall in apartment last week. The fall caused a small right medial elbow bruise and lower right rib pain without reported head injury. Skilled nursing requested for wound care of a non-pressure chronic ulcer of the right ankle limited to breakdown of skin. New bandage applied upon completion of shower on R ankle and bilateral compression stockings applied. Pt VS within normal parameter for pt, assessment completed. No further concerns.

- Skilled home care referral for evaluation and admission if appropriate, with skilled nursing requested for wound care of a non-pressure chronic ulcer of the right ankle limited to breakdown of skin. PCP wound-care orders are to cleanse with saline three days per week, apply petrolatum gauze and roll gauze until healed, with the home health nurse permitted to suggest alternative dressings/treatments. (Source: Home Health Care Evaluation, p. 7; Outgoing Referral, pp. 3-4)

- Homebound documentation states that travel outside the home is medically necessary in lieu of an office visit because the patient needs assistance with multiple ADLs, has cognitive impairment limiting mobility, and lives in an assisted living facility due to chronic conditions. (Source: Home Health Care Evaluation, p. 7)

- Recent medical history: The 09/01/2026 assisted-living visit addressed persistent right lateral ankle pain and evaluation after a fall in the shower on 08/31/2026. Prior ankle x-ray showed arthritis. The fall caused a small right medial elbow bruise and lower right rib pain without reported head injury. Low-dose gabapentin was started for right ankle neuropathy, and scheduled ondansetron was ordered for chronic nausea. Parkinson's disease, hypertension, paroxysmal atrial fibrillation, chronic kidney disease, and diabetes were described as stable on the current regimen.

SN GOALS

PATIENT-STATED GOAL: Heal wound on R ankle.

GOALS
patient/caregiver recalls
* how to keep home safe for patient with dementia
* coping strategies for the caregiver* 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
* 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
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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

of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, 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, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, 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, * strategies to increase socialization, related medication(s) purpose, schedule	* bowel incontinence management including dietary changes * bowel training * skin 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 * strategies to minimize fatigue and exhaustion including work simplification * energy conservation * lifestyle changes * diet * 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/caregiver recalls * strategies to increase socialization * recalls related medication(s) purpose, schedule

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: ALEXIS ABRAHAM SN RN on 09/10/2026

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. F2F date: 09/01/2026	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 **ROSE MARY SPELLMAN** 801 ROSE HILL DRIVE JACKSON, MI 49202 NPI 1154808418	**Phone Number** (517) 212-2008 **Fax Number** 15172122007

Physician's Signature and Date Signed

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ROSE MARY SPELLMAN, MD
09/01/2026: Date of physician last face-to-face