HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951515

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
X3LM61594396	09/10/2026	09/10/2026 - 11/08/2026	567-1	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Barbara Scherping 900 Hayes Rd Apt B1 Gaylord, MI 49735	Female	09/22/1934	(989) 732-6200
	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:
Wound on left forearm	The home visit was medically necessary in lieu of the office visit because Cognitive impairment limited mobility

ICD-10 CM Principal Diagnosis: M79.89. Other specified soft tissue disorders

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
J44.9	Chronic obstructive pulmonary disease unspecified	ACETAMINOPHEN 500 MG mg by mouth every six hours as needed (PRN) for Pain BUDESONIDE 0.5 MG mg/2 mL nebulizer using nebulizer twice a day SIMVASTATIN 5 MG mg by mouth at bedtime FUROSEMIDE 20 MG mg PO once daily at 10 AM. Note to staff: administer at 10 AM every morning PO LIDOCAINE 4% topical Apply 1 a small amount topical three times a day as needed (PRN) LOPERAMIDE HYDROCHLORIDE 2 MG mg by mouth once a day LORATADINE 10 MG mg by mouth once a day PANTOPRAZOLE 40 MG mg by mouth ONE TABLET ONCE DAILY IPRATROPIUM 0.5 MG mg-3 mg(2.5 mg base)/3 mL nebulizer Inhale 1 vial using nebulizer four times a day as needed (PRN) MULTIVITAMIN 1 tablet by mouth once a day POTASSIUM 10 mEq by mouth once a day OCUVITE 250 MG mg by mouth once a day MYRBETRIQ 25 MG mg by mouth once daily in the afternoon, for overactive bladder and functional urinary in ASPIRIN 81 MG mg by mouth once a day
R60.0	Localized edema	
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	
D72.828	Other elevated white blood cell count	
N32.81	Overactive bladder	

Prognosis	Mental and Psychosocial Status
fair	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	**Activities Permitted**
Hearing, Ambulation, Bowel/Bladder Incontinence, Endurance	Up As Tolerated, Walker
DME & Supplies	**Safety Measures**
bath bench, wound care supplies, 4 wheeled walker	walker precautions, fall precautions, ambulates with device, bathroom safety
Nutrition	**Allergies**
regular	Tramadol, Oxycodone, Nsaids, Codeine, Adhesive Tape-silicones

Advance Directives	Caregiver Status
Living Will	1. Non-agency caregiver(s) currently provide assistance; 1. Non-agency caregiver(s) currently provide assistance
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.	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: 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

09/13/2026 Problems : #1 - Abrasion - Anterior Left Elbow/Forearm - car door scraped arm
M1600 - UTI
M1610 - Urinary Incontinence
M1033 - Exhaustion
M1400 - Dyspnea
M2020 - Oral Med Management
limited endurance
limited strength
frequent urination
bruising/discoloration
B0200 - Hearing Deficit

PROCEDURES: physician-ordered wound care: #1 - Abrasion - Anterior Left Elbow/Forearm - car door scraped arm: Steri strips currently in place, do not remove- apply skin prep around wound and place mepilex dressing over wound bed. Remove mepilex and reapply Q3 days., bladder training

TEACH PATIENT/CAREGIVER: * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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 hearing-impaired including installing special fire-detector/CO2 alarms, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

SN NARRATIVE

PCP: pt unsure says at OMH

Upon arrival to the Brooks where pt resides pt was in her apartment B1. Barbie was in the bathroom getting ready and upon arrival ambulated to recliner in living with walker. Barbie states she was coming back to the Brooks from her daughters home and her car door flung closed and scraped her L arm and bruised significantly- pt states she believes it happened on Monday. Pt states no other concerns. VS within normal parameters for pt, assessment completed.

- Home health referral dated 09/09/2026 requests skilled home care evaluation/admission if appropriate and skilled nursing wound care for a left forearm wound. Wound care orders are to cleanse with saline three days per week, apply petrolatum gauze, and secure with loose roll gauze; no Coban or Ace wrap. The home health nurse may suggest alternative dressing or wound treatment as appropriate. (Source: Outgoing Referral, pp. 3-4; Home Health Care Evaluation, p. 7.)

- Recent medical history: At the 08/31/2026 assisted-living visit, the patient was evaluated for slightly elevated white blood cell count, urinary frequency with worsening nighttime incontinence, mild wheezing/difficulty breathing in humid or heavy weather, and hip/sacral soreness. Urinalysis was ordered to evaluate for possible urinary infection; Myrbetriq was started for overactive bladder/functional urinary incontinence; furosemide was reduced from 40 mg to 30 mg daily and directed for morning administration; scheduled budesonide and PRN ipratropium-albuterol nebulizer treatment were continued; and a lidocaine patch was recommended for sacral pain. The sacral skin was intact at that visit with the previous left sacral wound documented as completely healed.

SN GOALS

PATIENT-STATED GOAL: Heal skin tear/bruising Larm.

GOALS
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
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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 hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

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

Scherping, Barbara | Cert Period 09/10/26 - 11/08/26

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: 08/31/2026	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

X

ROSE MARY SPELLMAN, MD
08/31/2026: Date of physician last face-to-face