HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951499

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
7TX6T37MH63	09/08/2026	09/08/2026 - 11/06/2026	974	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Jim Mshar 2736 Plywood Rd GAYLORD, MI 49735	Male	07/16/1941	(989) 731-4020
	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:
Home Care Referral Agency: Evergreen HHC Service Requested: PT Dx: G30.1 Alzheimer's disease with late onset F02.B11 Dementia in other diseases classified elsewhere, moderate, with agitation F41.1 Generalized anxiety disorder F51.05 Insomnia due to other mental disorder	Patient lives in assisted living facility due to chronic conditions

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

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
F02.B11	Dem in other dis classd elswhr moderate with agitation	ACETAMINOPHEN 500 MG tablet by mouth three times a day as needed (PRN) ARICEPT 5 MG tablet by mouth at bedtime CARISOPRODOL COMPOUND 1 pad to affected area as directed LATANOPROST 1 drops both eyes once a day LORAZEPAM 0.5 MG tablet by mouth twice a day as needed (PRN) for Anxiety MIRTAZAPINE 15 MG mg by mouth at bedtime PATADAY 1 drops into both eyes twice a day PREDNISONE 10 MG tablet by mouth twice a day SEROQUEL 100 MG tablet by mouth twice a day CITALOPRAM 10 MG tablet by mouth once a day GUAIFENESIN 400 MG tablet by mouth three times a day TIMOLOL 1 drops into right eye twice a day
F41.1	Generalized anxiety disorder	
F51.05	Insomnia due to other mental disorder	
C61.	Malignant neoplasm of prostate	
R26.81	Unsteadiness on feet	

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: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required, 2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, 3. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc., 4. Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects), 5. Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions), 6. Delusional, hallucinatory, or paranoid behavior, HISTORY OF DEPRESSION: Yes
Functional Limitations Bowel/Bladder Incontinence, Endurance, Hearing, Ambulation	**Activities Permitted** Up As Tolerated
DME & Supplies grab bars, bath bench	**Safety Measures** fall precautions, cardiac precautions, bathroom safety
Nutrition regular	**Allergies** no known allergies

Mshar, Jim | Cert Period 09/08/26 - 11/06/26

Advance Directives	Caregiver Status
Pts son	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 PT: family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:
SN. PT to eval and treat

SN CAREPLAN

SN frequency WK1: 1 (09/08/26-09/12/26)

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:Pts son

09/16/2026 Problems : #1 - Other - Posterior Left Ankle/Foot - Plantar wart bottom of L foot- Nurse at assisted living has specific bandages to trx wart.
M1700 - Cognition
M1720 - Anxiety
D0700 - Social Isolation
M1745 - Behavioral Issues
M1830 - Bathing
M1610 - Urinary Incontinence
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M1870 - Self Feeding
M2020 - Oral Med Management
balance deficit
open sores/lesions
B0200 - Hearing Deficit
B1000 - Vision Deficit
D0160 - Depression

PROCEDURES: physician-ordered wound care: #1 - Other - Posterior Left Ankle/Foot - Plantar wart bottom of L foot- Nurse at assisted living has specific bandages to trx wart.: RN at facility has specific bandaids to apply to plantars wart, bladder training, assist with fall prevention, assist with assistive devices prn

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats,

SN NARRATIVE

Frequency: discharged from SN, only requires PT services.

Upon arrival knocked on door, nurse opened door and directed me to pt. Pt was ambulating independently, does not use assistive device. Pt has Dementia and Alzheimer's and repetitively asked the same questions and was confused through most of the assessment. Pt was cooperative and completed the assessment fully with no issues. RN at facility states pt can show aggressive, physical, and verbally aggressive behaviors. Did not observe any of these at the visit today. Pt did get agitated at times not understanding who ordered PT and why I was there but when explained he was agreeable. Pt does have a plantars wart on bottom of L foot that the facility has special bandaids for trx. VS within normal parameters for pt, assessment completed. No further concerns.

- On 09/08/2026, skilled homecare was ordered to evaluate and admit to service if appropriate, with PT requested for evaluation and treatment. Referral diagnoses were Alzheimer's disease with late onset, dementia in other diseases classified elsewhere with moderate agitation, generalized anxiety disorder, and insomnia due to other mental disorder.

- Recent medical history: At the 08/27/2026 facility visit, the patient was seen for increased anxiety, new delusions, pacing, and depletion of his lorazepam supply. He had previously shown improvement after quetiapine adjustment, but anxiety and delusions recurred. Examination documented increased generalized confusion, memory impairment, slow unsteady gait, and independent ambulation. The provider noted that a PT evaluation for a walker could be considered if he is able to follow directions to use one.

SN GOALS

PATIENT-STATED GOAL: Monitor Plantars wart on L foot

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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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
* 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
* 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

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 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, * 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, * 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	* skin care * diet modification * record wound measurements * 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/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

PT CAREPLAN
PT frequency WK1: 1 (09/08/26-09/12/26),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 (10/04/26-10/10/26)

09/15/2026 Problems : muscle weakness
limited strength
limited endurance

PROCEDURES: therapeutic exercises: B LE strengthening, gait training/stair training: with and without AD. Carryover with new AD may be limited, neuromuscular re-education: standing static and dynamic balance training, proprioception training. dual task balance training.

TEACH PATIENT/CAREGIVER: * pain control therapeutic exercises for muscle strengthening and flexibility diet and fluids to optimize and prevent constipation, related medication(s) purpose, schedule, Fall prevention, AD training

PT NARRATIVE
Patient referred for PT due to increased generalized confusion, memory impairment, slow unsteady gait, and independent ambulation. The PCP noted that a PT evaluation for a walker could be considered if he is able to follow directions to use one.

Patient has significant cognitive decline which impacts his ability to learn new skills such as using a walker. Patient demonstrates reduced balance and proprioception, dementia related posturing with limited arm swing, flexion of the hips and knees, and reduced lumbar lordosis. At this time patient will benefit from further skilled PT interventions to address balance and gait to reduce fall risk and improve safety during ADL's and ambulation carryover will be limited due to dementia. PT would not recommend walker use at this time but may be able to practice with a walker at future visits to assess safety and compliance. Patient reports he walks just fine and doesn't need a walker.

PT GOALS
PATIENT-STATED GOAL: Patient unable to verbalize goals due to dementia, staff report they would like to see him with improved stability to prevent future falls.

GOALS
patient/caregiver recalls
* pain control
* therapeutic exercises for muscle strengthening and flexibility
* diet and fluids to optimize and prevent constipation
* recalls related medication(s) purpose, schedule

Fall prevention

AD training

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 09/08/2026

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

X

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