HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951472

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
911374833	09/01/2026	09/01/2026 - 10/30/2026	951	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Martin Gedert 1585 cimowske rd MIO, MI 48647	Male	12/21/1961	(989) 244-5876
	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:
squamous cell carcinoma of the larynx	Symptoms identified support difficulty to leave home for medical services required.

ICD-10 CM Principal Diagnosis: Z48.813. Encntr for surgical aftcr following surgery on the resp sys

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
Z43.0	Encounter for attention to tracheostomy	ALBUTEROL 2.5 mg/3 mL Inh q6hr, PRN 0.083% inhalation solution BUSPIRONE HCL 5 mg Oral TID 5 mg= 1 Tab, 3 refills DUONEB 0.5 mg-2.5 mg/3 mL Inh QID, PRN inhalation solution GABAPENTIN 800 mg Oral TID 800 mg= 1 Tab, 3 refills LANTUS 60 unit Subcut QHS 100 units/mL subcutaneous solution LOSARTAN POTASSIUM 50 mg Oral Daily 50 mg= 1 Tab, 3 refills NORCO 10 mg-325 mg Oral q6hr, PRN 1 Tab PANTOPRAZOLE 40 mg Oral BID delayed release tablet, 40 mg= 1 Tab ROSUVASTATIN CALCIUM 40 mg Oral Prior to Bed 40 mg= 1 Tab, 3 refills VENTOLIN 90 mcg/inh Inh q6hr, PRN inhalation aerosol, 90 mcg= 1 Puff, 1 WELLBUTRIN 150 mg/24 hours Oral q24hr oral tablet, extended release, 150 mg= 1 Tab, 3 refills METFORMIN 1000 mg Oral BID 1000 mg= 1 Tab XARELTO 20 mg Oral qPM 20 mg= 1 Tab, 3 refills TRULICITY 4.5 mg/0.5 mL Subcut Weekly subcutaneous solution, 3 refills FARXIGA 10 mg Oral Daily 10 mg= 1 Tab, 3 refills DUTASTERIDE AND TAMSULOSIN HYDROCHLORIDE 0.4 mg Oral qAM oral capsule, 0.4 mg= 1 Cap
C32.8	Malignant neoplasm of overlapping sites of larynx	
J44.9	Chronic obstructive pulmonary disease unspecified	
E11.65	Type 2 diabetes mellitus with hyperglycemia	
Z86.711	Personal history of pulmonary embolism	
I10.	Essential (primary) hypertension	
E78.5	Hyperlipidemia unspecified	

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: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes
Functional Limitations Endurance	**Activities Permitted** Up As Tolerated
DME & Supplies trach supplies	**Safety Measures** standard precautions, O2 precautions, fall precautions, bathroom safety
Nutrition regular	**Allergies** Bee Stings, No Known Medication Allergies

Advance Directives
No Advance Directive

Caregiver Status
2. Non-agency caregiver(s) need training/supportive services to provide assistance; 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

Orders for Discipline and Treatment:
SN to eval and treat

SN CAREPLAN

SN frequency WK1: 1 (09/01/26-09/05/26),WK2: 1 (09/06/26-09/12/26),WK3: 1 (09/13/26-09/19/26),WK4: 1 (09/20/26-09/26/26),WK5: 1 (09/27/26-10/03/26),WK6: 1 (10/04/26-10/10/26),WK7: 1 (10/11/26-10/17/26),WK8: 1 (10/18/26-10/24/26)

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: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 3. Multiple hospitalizations (2

or more) in the past 6 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

09/01/2026 Problems : D0700 - Social Isolation
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
coughing
difficulty sleeping
daytime fatigue
impaired speech
balance deficit
limited endurance
constipation
abnormal BS < 70/140 > mg/dL
D0160 - Depression
M2102d - Caregiver Performs Treatment

PROCEDURES: tracheostomy care: Patient/caregiver educated on tracheostomy care, including hand hygiene, cleaning of the trach site, changing/cleaning inner cannula as ordered, suctioning technique, humidification, and maintaining clean/dry trach ties and dressing. Reviewed signs/symptoms of infection or respiratory distress, including increased secretions, change in secretion color/odor, redness/swelling, difficulty breathing, or inability to clear secretions. Emergency precautions and when to call 911 reviewed. Patient/caregiver verbalized understanding of education provided., cough/deep breathing exercises, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor,

SN NARRATIVE

Reason for Home Health Referral

- Home care referral was ordered after a face-to-face encounter for RN services because symptoms were identified as supporting difficulty leaving home for required medical services. The order specifically requests RN care for a new tracheostomy placed 08/23/2026 in the setting of squamous cell carcinoma of the larynx. (Source: Home Care Referral order, 08/24/2026)

- Recent hospitalization: Patient transferred from Grayling for increased shortness of breath and concern for airway obstruction with newly diagnosed laryngeal squamous cell carcinoma. Imaging showed persistent irregular soft tissue thickening along the right true vocal cord. He underwent tracheostomy on 08/23/2026 for worsening airway symptoms/airway obstruction. Speech therapy evaluated swallowing after tracheostomy; videofluoroscopy showed no penetration or aspiration and recommended IDDSI 6 soft and bite-size solids with thin liquids. (Sources: H&P, 08/22/2026; ENT Consultation, 08/23/2026; Operative Report, 08/23/2026; Speech Therapy Progress Notes, 08/24/2026)

SN GOALS

PATIENT-STATED GOAL: be able to independently manage trach;have less pain

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
* 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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

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

caregiver performs medical/rehabilitation treatments with adequate competence

coordinate/arrange long-term socialization activities 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 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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule, caregiver performs medical/rehabilitation treatments with adequate competence	

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAVANNAH GRANDCHAMP SN RN on 09/01/2026

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: 08/25/2026	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 **NATIKA COWIE** 1321 S Mt Tom Rd Mio, MI 48647 NPI 1861202574	**Phone Number** (989) 344-5820 **Fax Number** 12313927338

Physician's Signature and Date Signed

X

NATIKA COWIE, NP
08/25/2026: Date of physician last face-to-face