HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195972

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
X3L917450027	07/23/2026	07/23/2026 - 09/20/2026	849	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Eleanor Rich 568 e sheldon st GAYLORD, MI 49735	Female	02/14/1929	9897324304
	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:
p[ost op ostomy placement	patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home

ICD-10 CM Principal Diagnosis: Z48.815. Encntr for surgical aftcr following surgery on the dgstv sys

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
Z93.2	Ileostomy status	Immodium - Loperamide Hydrochloride 2mg by mouth as necessary Magnesium - Simethicone 500mg 1 tab by mouth once a day Ocuvite - Normal Saline 1 tab by mouth once a day
K56.609	Unsp intestnl obst unsp as to partial versus complete obst	
K63.89	Other specified diseases of intestine	
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	
I10.	Essential (primary) hypertension	
N18.32	Chronic kidney disease stage 3b	
E53.8	Deficiency of other specified B group vitamins	

Prognosis	Mental and Psychosocial Status
Good	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 Hearing, Ambulation, Endurance	**Activities Permitted** Up As Tolerated, Walker, Independent at Home
DME & Supplies bath bench, walker	**Safety Measures** ambulates with device, fall precautions, walker precautions,
Nutrition soft	**Allergies** Dust, Grass, Statins

Advance Directives	Caregiver Status
No Advance Directive	1. Non-agency caregiver(s) currently provide assistance; 0. No assistance needed - patient is independent or does not have needs in this area
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.	family/caregiver will be responsible for managing treatment patient will be responsible for managing treatment add discharge plan

Orders for Discipline and Treatment:

1 - SOC - SN

PT Eval: eval and treat

OT Eval

4 - Recertification

SN CAREPLAN

SN frequency WK1: 1 (07/23/26-07/25/26),WK2: 1 (07/26/26-08/01/26),WK3: 1 (08/02/26-08/08/26),WK4: 1 (08/09/26-08/15/26),WK5: 1 (08/16/26-08/22/26),WK6: 1 (08/23/26-08/29/26),WK7: 1 (08/30/26-09/05/26),WK8: 1 (09/06/26-09/12/26),WK9: 1 (09/13/26-09/19/26),WK10: 1 (09/20/26-09/20/26)

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: 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

07/23/2026 Problems : M1630 - GI Ostomy
M1033 - Exhaustion
M1400 - Dyspnea
M2020 - Oral Med Management
limited strength
limited endurance
B1000 - Vision Deficit

PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: Ostomy care, physician-ordered wound care: Ostomy care, physician-ordered wound care: Ostomy care/stoma observation, apply collection/fistula pouch, ostomy care & irrigation, monitor intake & output, 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, * ostomy management including how to clean stoma change ostomy pouch, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related

SN NARRATIVE

July 16th-22nd hospitalized Gaylord Munson. Ostomy placed, pt states staff was adequate with education and very informative. Continued education and monitoring of ostomy/stoma needed. Scott pts son lives with pt his phone number is 9893706533.

- Home health referral for RN, PT, OT, and Home Health Aide services for post-operative care after exploratory laparotomy, transverse colon resection with anastomosis, and creation of a diverting loop ileostomy; new ostomy education and management; weakness, gait/mobility deficits, ADL support, and difficulty leaving home for required medical services.
- The patient was admitted with approximately 3 months of abdominal cramping/change in bowel habits and 3 weeks of worsening generalized abdominal pain, dark emesis, poor appetite, and weight loss. CT showed a 7 cm hepatic-flexure/transverse-colon mass causing high-grade bowel obstruction. On 07/17/2026, she underwent exploratory laparotomy with segmental transverse colon resection, anastomosis, diverting loop ileostomy, and omental patch. The operative report documented no gross metastatic disease and no complications. Post-operatively, she received ostomy teaching, progressed to a soft low-fiber diet, began loperamide for high ileostomy output, and participated in PT/OT for weakness, gait, transfers, ADLs, safety, and fall prevention.
- Alert, oriented, and fully oriented; no focal neurological deficits documented. Mentation described as good for age.
- Bilateral hearing impairment; uses bilateral hearing aids.
- Prior to admission, independent with self-care and mobility without a device; son assisted with cooking, cleaning, and shopping.
- During hospitalization, ambulated 300 feet with a front-wheeled walker and standby assistance without loss of balance, shortness of breath, or rest breaks. Transfers and mobility required standby assistance/supervision. Lower-extremity dressing required standby assistance; toileting and toilet transfers required supervision/setup. OT documented fair activity tolerance and mild abdominal pain.

July 16th-22nd hospitalized Gaylord Munson. Ostomy placed, pt states staff was adequate with education and very informative. Continued education and monitoring of ostomy/stoma needed. Incision on abdomen with dressing covering supposed to remain on incision until falls off on its own- goes in Monday for f/u appt. Ostomy observed and no s/s of infection or concerns at this time.

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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

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SN GOALS
PATIENT-STATED GOAL: Pt independently change ostomy and manage care for ostomy.

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
* ostomy management including how to clean stoma
* change ostomy pouch
* 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

OT CAREPLAN
OT frequency WK4: 1 (08/09/26-08/15/26)

08/12/2026 Problems : M1400 - Dyspnea
GG0130B1 - Oral Hygiene
GG0130C1 - Toileting Hygiene
GG0130E1 - Shower/Bathe Self
GG0130G1 - Lower Body Dressing
GG0130H1 - Don/Doff Footwear
GG0130A1 - Eating
GG0130F1 - Upper Body Dressing

PROCEDURES: cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation

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, Oral Hygiene - 06. Independent, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 05. Setup or clean-up assistance, Upper Body Dressing - 06. Independent

OT NARRATIVE
PT is home following a hospitalization for bowel resection and ostomy which may be reversible. PT was independent in ADL's prior to sx. Son Scott lives with her and takes care of home and all IADL's. PT was active in walking club and balance classes. PT is ambulating without assistive device but does have 2ww when needed. PT is able to dress UB and toilet independently but requires min a for LB dressing. PT is mod a for ostomy replacement and empty at this point in time. She is able to reach down to feet if in proper position and edu provided to place a captains dining chair with arms in her room to dress self from and that she will most likely be able to complete safely. PT is having a home health aid come in for showering. EDU provided on grab bar placement, hand held shower head and bath mat as well as a trial of TTB which PT did not care for as she would have to remove shower doors. PT does have a non adjustable shower chair in a tub/shower situation where her feet caught on during trial tf. TTB was recommended for that reason. PT will think about it and if she needs it to be independent in the future she will obtain one. EDU for a bed mobility bar as bed is very high. PT is able to manage it right now using 2ww. Son is caring for her needs very well and she is able to care for most of her needs. EDU provided to son to assist as needed but allow her the time to trial putting her own LB clothing on and become more and more SBA. He verbalized understanding. No further skilled OT services at this time

OT GOALS
PATIENT-STATED GOAL: add patient-stated goal

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

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

Oral Hygiene - 06. Independent

Toileting Hygiene - 05. Setup or clean-up assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

	Eating - 05. Setup or clean-up assistance Upper Body Dressing - 06. Independent

PT CAREPLAN

PT frequency WK2: 1 (07/26/26-08/01/26),WK3: 1 (08/02/26-08/08/26),WK4: 1 (08/09/26-08/15/26),WK5: 1 (08/16/26-08/22/26),WK6: 1 (08/23/26-08/29/26),WK7: 1 (08/30/26-09/05/26),WK8: 1 (09/06/26-09/12/26),WK9: 1 (09/13/26-09/19/26),WK10: 1 (09/20/26-09/20/26)

08/12/2026 Problems : GG0170D1 - Sit to Stand
GG0170F1 - Toilet Transfer
GG0170G1 - Car 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
GG0170E1 - Chair to Bed to Chair

PROCEDURES: home exercise program, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, 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, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance

PT NARRATIVE

Patient was hospitalized about 6 days due to bowel obstruction and ileostomy on 7/17/26. She just got staples removed on 7/27/26. Patient reports she feels she has come a long way. Getting up out of the chair is still difficult. Patient reports she has been walking with the walker about 4 laps around the house 3 x/day. Patient demonstrates reduced B LE strength and balance deficits, tinetti 14/28 indicating high fall risk, difficulty with transfers and slow cadence.
Patient will benefit from skilled PT interventions to address strength, balance, endurance, sit to stands, HEP instruction and gait training to be able to return to PLOF.
Patient reports she would love to be able to walk without the walker and get back to her senior walking club 3 times/week. and other exercise classes at the senior center.

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PT GOALS

PATIENT-STATED GOAL: regain independence

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

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

Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

12 Steps - 05. Setup or clean-up assistance

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

Car Transfer - 06. Independent

Sit to Stand - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: KENDRA CHURCHES SN RN on 07/23/2026

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.

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 **CHANGXIN LI**
829 N CENTER AVE SUITE 140
GAYLORD, MI 49735-1595
NPI 1114958899

Phone Number (989) 731-7870

Fax Number 19897317837

Physician's Signature and Date Signed

X

CHANGXIN LI, MD

: Date of physician last face-to-face