HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195959

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
943286043	07/30/2026	07/30/2026 - 09/27/2026	862	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Rosilee Toth 7725 M 32 E JOHANNESBURG, MI 49751	Female	01/21/1950	(989) 858-3764
	Email		Primary Language: English

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:
- Home care referral ordered for RN and Physical Therapy following hospitalization for COPD with difficulty leaving home for required medical services. - Patient was hospitalized for worsening shortness of breath with acute hypoxia and COPD exacerbation/acute on chronic hypoxic respiratory failure. She was treated with oxygen, IV corticosteroids transitioned to oral prednisone, antibiotic therapy, nebulizer treatments, incentive spirometry, and Acapella therapy. She improved to room air by discharge and was instructed to follow up with primary care and pulmonology.

Physician Statement on Homebound Status:
Symptoms identified support difficulty to leave home for medical services required.

ICD-10 CM Principal Diagnosis: J96.21. Acute and chronic respiratory failure with hypoxia

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
J30.1	Allergic rhinitis due to pollen	PREDNISONE 20 MG tab(s) by mouth Every day Duration: 3 Days Pickup at WALGREENS DRUG STORE #10404 NORCO 7.5 MG tab(s) by mouth Every 4 hours as needed for Moderate-Severe Pain Chronic low back pain with sciatica Chronic back pain greater than 3 months duration Acute bilateral low back pain with bilateral sciatica Duration: 30 Days To be taken every 4 to 6 hours for moderate to severe pain, not to exceed 5 tablets/day ALBUTEROL 2 inh inhalation Every 4 hours as needed for wheezing albuterol-ipratropium (albuterol-ipratropium 2.5 mg-0.5 mg /3 mL inhalation solution) 2.5 MG Milliliter nebulized inhalation 4 times a day as needed for Wheezing Pickup at WALGREENS DRUG STORE #10404 CARVEDILOL 3.125 MG tab(s) by mouth 2 times a day fluticasone/umeclidinium/vilanterol (Trelegy Ellipta 100 mcg-62.5 mcg-25 mcg/ inh inhalation powder) 1 puff(s) inhaled Every day at the same time every day FUROSEMIDE 20 MG tab(s) by mouth Every day as needed for edema LOSARTAN POTASSIUM 100 MG tab(s) by mouth Every day LYRICA 200 MG cap by mouth 2 times a day ROSUVASTATIN CALCIUM 40 MG tab(s) by mouth Every day
F41.1	Generalized anxiety disorder	
E78.2	Mixed hyperlipidemia	
M81.0	Age-related osteoporosis w/o current pathological fracture	
I73.89	Other specified peripheral vascular diseases	
M65.331	Trigger finger right middle finger	
J96.21	Acute and chronic respiratory failure with hypoxia	

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 Endurance	**Activities Permitted** Independent at Home, Up As Tolerated
DME & Supplies grab bars	**Safety Measures** medication safety, O2 precautions, fall precautions

Nutrition	Allergies
regular	codeine, Cymbalta, DULoxetine, morphine, NSAIDs, penicillin, pentazocine, Talwin

Toth, Rosilee | Cert Period 07/30/26 - 09/27/26

Advance Directives
No Advance Directive

Caregiver Status
0. No assistance needed - patient is independent or does not have needs in this area; 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:
patient will be responsible for managing treatment
add discharge plan

Orders for Discipline and Treatment:
1 - SOC - SN

PT Eval

4 - Recertification

SN CAREPLAN

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

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: 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

07/30/2026 Problems : M1720 - Anxiety
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
Home Safety
wheezing
lung sounds not clear
limited strength
limited endurance
constipation

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange for maintenance of clean/uncluttered living area

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, * prevention exacerbation of anxiety

SN NARRATIVE

Hospitalized OMH Munson 7/25-29. Pt states had SOB dx COPD exacerbation.

- Home care referral ordered for RN and Physical Therapy following hospitalization for COPD with difficulty leaving home for required medical services.
- Patient was hospitalized for worsening shortness of breath with acute hypoxia and COPD exacerbation/acute on chronic hypoxic respiratory failure. She was treated with oxygen, IV corticosteroids transitioned to oral prednisone, antibiotic therapy, nebulizer treatments, incentive spirometry, and Acapella therapy. She improved to room air by discharge and was instructed to follow up with primary care and pulmonology.

- Asthma-COPD overlap syndrome with home oxygen use at night.
- Chronic back pain, lumbar spondylosis, neuropathy of both feet, osteoarthritis of the knee, osteoporosis, peripheral vascular disease, generalized anxiety disorder, hyperlipidemia, essential hypertension, gastroesophageal reflux disease, allergic rhinitis, and migraines.
- No tobacco use documented; electronic cigarette/vaping use documented as never.

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SN GOALS

PATIENT-STATED GOAL: Lung sounds to be clear and regain strength from COPD exacerbation.

GOALS
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
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath

condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, patient's living environment is clean/uncluttered	* 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 * 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's living environment is clean/uncluttered

PT CAREPLAN
PT frequency WK2: 1 (08/02/26-08/08/26)

08/03/2026 Problems : GG0170G1 - Car Transfer
GG0170P1 - Picking Up Object
GG0170O1 - 12 Steps
GG0170N1 - 4 Steps
GG0170M1 - 1 - Step (curb)
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170K1 - Walk 150 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170I1 - Walk 10 Feet
GG0130B1 - Oral Hygiene
GG0170E1 - Chair to Bed to Chair
GG0170D1 - Sit to Stand
GG0130C1 - Toileting Hygiene
GG0170F1 - Toilet Transfer
GG0130E1 - Shower/Bathe Self
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130F1 - Upper Body Dressing

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 - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

PT NARRATIVE
Patient was hospitalized for 4 days for worsening shortness of breath with acute hypoxia and COPD exacerbation/acute on chronic hypoxic respiratory failure. She was treated with oxygen, IV corticosteroids transitioned to oral prednisone, antibiotic therapy, nebulizer treatments, incentive spirometry, and Acapella therapy. She improved to room air by discharge.

Patient is ambulating without any AD, reports she tires out quickly but has been doing her usual ADL's. Reporting chronic low back pain has increased somewhat since being in the hospital. At this time the patient is doing well with home activities. PT instructed breathing exercises, and lumbar mobility activities for HEP, educated on use of incentive spirometer and flute for improved lung function. Patient demonstrated all with good understanding. PT educated on energy conservation, and fall prevention techniques.

Patient was hospitalized for 4 days for worsening shortness of breath with acute hypoxia and COPD exacerbation/acute on chronic hypoxic respiratory failure. She was treated with oxygen, IV corticosteroids transitioned to oral prednisone, antibiotic therapy, nebulizer treatments, incentive spirometry, and Acapella therapy. She improved to room air by discharge.

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

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Upper Body Dressing - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 07/30/2026

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: 07/29/2026

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 **TABITHA PARDO** 825 N CENTER AVE STE 140 GAYLORD, MI 49735-1592 NPI 1548852130	**Phone Number** (989) 731-7870 **Fax Number** 19897317837

Physician's Signature and Date Signed

X

TABITHA PARDO, FNP-C

07/29/2026: Date of physician last face-to-face