HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195895

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
4F13EG3MY09	08/17/2026	08/17/2026 - 10/15/2026	923	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Ronald Provo 5908 E US 23 HWY CHEBOYGAN, MI 49721	Male	04/04/1940	(231) 818-2855
	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:
management of sarcopenia with associated atherosclerotic heart disease, prior stroke, dysphagia, pain, and recent functional decline. The SOC narrative documents increased weakness/fatigue and inability to ambulate, with the patient primarily bed- or recliner-bound. - Recent medical history: The SOC narrative documents hospitalization from 07/28/2026 through 08/07/2026 after presentation with abdominal pain and jaundice; the patient was diagnosed with cholecystitis and underwent cholecystectomy. During/after the acute illness he had dysphagia, restricted diet advancement, abdominal pain worsened by food intake, and marked decline in mobility and function. The hospital name is not documented.

Physician Statement on Homebound Status:
BEDBOUND

ICD-10 CM Principal Diagnosis: M62.84. Sarcopenia

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	VITAMIN 1 tablet ORAL DAILY CYANOCOBALAMIN 1000 mcg ORAL DAILY HYOSCYAMINE 0.125 MG tablet SUBLINGUAL EVERY 4 HOURS LIDOCAINE 2 adhesive patch TOPICAL DAILY REMOVE 12 HOURS LORAZEPAM 0.5 MG tablet ORAL EVERY 4 HOURS METHOCARBAMOL 750 MG mg ORAL 3 TIMES DAILY METOPROLOL 50 MG mg ORAL 2 TIMES DAILY OMEPRAZOLE 20 MG mg ORAL EVERY AM TAKE EVERY MORNING ON EMPTY STOMACH ONDANSETRON 4 MG tablet ORAL EVERY 4 HOURS Primlev 10 MG tablet ORAL EVERY 6 HOURS OXYGEN 2-4 Liter INHALATION Q2 - PRN PLAVIX 75 MG mg ORAL DAILY PREGABALIN 150 MG mg ORAL DAILY PROSCAR 5 MG mg ORAL 2 TIMES DAILY SENNA 8.6 MG tablet ORAL DAILY SIMVASTATIN 10 MG mg ORAL EVERY PM DUTASTERIDE AND TAMSULOSIN HYDROCHLORIDE 0.4 MG mg ORAL DAILY TAKE WITH BREAKFAST
E46.	Unspecified protein-calorie malnutrition	
J44.9	Chronic obstructive pulmonary disease unspecified	
I63.9	Cerebral infarction unspecified	
R13.12	Dysphagia oropharyngeal phase	
L89.322	Pressure ulcer of left buttock stage 2	
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: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No
Functional Limitations	**Activities Permitted**
Endurance, Bowel/Bladder Incontinence, Ambulation	Up As Tolerated, Exercises Prescribed, Transfer bed/Chair

DME & Supplies	Safety Measures
wheelchair, , hospital bed	activity supervision, fall precautions, O2 precautions, transfer with assist
Nutrition	**Allergies**
Z. NO PHYSICIAN-ORDERED DIET	NKA

Advance Directives	Caregiver Status
No Advance Directive	1. Non-agency caregiver(s) currently provide assistance
Rehabilitation Potential SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.	**DISCHARGE PLAN:** family/caregiver will be responsible for managing treatment add discharge plan

Orders for Discipline and Treatment:

1 - SOC - PT

OT Eval

OT NARRATIVE

Patient, DOB 4/4/1940, is an 86-year-old male referred for home health OT following hospitalization from 7/28/26–8/7/26 with cholecystectomy and subsequent discharge home with hospice services. Patient presents with significant functional decline, generalized weakness, decreased core strength, poor activity tolerance, and inability to ambulate. Patient is primarily bed/recliner bound and requires caregiver assistance for the majority of ADLs.

Patient resides in a single-level home with wife, who serves as primary caregiver. Patient also receives aide assistance with sponge bathing 2x/week. Patient utilizes briefs and handheld urinal for toileting. He demonstrates fair bed mobility with ability to roll/weight shift bilaterally to assist with hygiene, brief management, positioning, and pressure relief. Patient independently completes UB dressing and requires approximately Mod A for LB dressing. Significant core weakness and decreased endurance noted, with fatigue occurring after approximately 3 minutes of functional weight-shifting/activity.

Skilled OT intervention provided this date included instruction in bed mobility, positioning, and pressure-relief techniques to reduce risk of skin breakdown. Patient demonstrates good ability to utilize hospital-bed trapeze/triangle bar to assist with repositioning. Patient/caregiver instructed in safe transfer and body-mechanics techniques to decrease fall/injury risk and caregiver burden. Gait belt use was recommended as appropriate. Caregiver reports current wheelchair has fixed armrests limiting ability to perform slide-board transfers and is pursuing a wheelchair with removable/drop-away armrests to improve transfer accessibility.

Patient instructed in gentle BUE theraband exercises targeting functional strength required for repositioning, pushing from seated surfaces, and assisting with transfers. Education provided regarding pacing, energy conservation, frequent rest breaks, and completion of activity within tolerance. Patient/caregiver also instructed in compensatory ADL strategies, including use of reacher/grabber and environmental setup of frequently needed items within accessible reach to maximize patient participation and decrease caregiver assistance.

Due to hospice status and current level of function, OT focus is on comfort, safety, positioning/pressure relief, maintenance of functional participation as tolerated, environmental modification, caregiver education, and reduction of caregiver burden rather than restorative rehabilitation. Patient and caregiver demonstrated understanding of education and recommendations provided during evaluation. Skilled OT needs were addressed through evaluation, education, and caregiver training this date. No further skilled OT visits are indicated at this time. Patient discharged from OT following evaluation with continued hospice/caregiver support.

OT GOALS

PATIENT-STATED GOAL: add patient-stated goal

GOALS

PT CAREPLAN

PT frequency WK1: 1 (08/17/26-08/22/26),WK3: 1 (08/30/26-09/05/26)

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), 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 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

08/24/2026 Problems : GG0170R1 - Wheel 50 ft w 2 Turns
GG0170G1 - Car Transfer
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
GG0130B1 - Oral Hygiene
GG0130A1 - Eating
GG0170S1 - Wheel 150 feet
M1033 - Unintentional Weight Loss
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
swelling in the arms/legs
balance deficit
weak hand grips
muscle weakness
poor muscle tone
limited strength
limited endurance

PROCEDURES: cough/deep breathing exercises, incentive spirometer, wheelchair training, home exercise program: instruct and progress HEP to include supine and seated exercises for improve LE strength and seated balance to improve safety during transfers, equipment training: slide board and trapeze use, work simplification/energy conservation, transfers training: slide board transfers to and from w/c or BSC

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, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, Chair to Bed to Chair - 02. Substantial/maximal assistance, Toilet Transfer - 01. Dependent, Wheel 50 ft w 2 Turns - 01. Dependent, Wheel 150 feet - 01. Dependent

PT NARRATIVE

Patient is bed bound. Was discharged to home with hospice. RN start of care and hospice services for management of sarcopenia with associated atherosclerotic heart disease, prior stroke, dysphagia, pain, and recent functional decline. The SOC narrative documents increased weakness/fatigue and inability to ambulate, with the patient primarily bed- or recliner-bound. Hospitalization from 07/28/2026 through 08/07/2026 after presentation with abdominal pain and jaundice; the patient was diagnosed with cholecystitis and underwent cholecystectomy. During/after the acute illness he had dysphagia, restricted diet advancement, abdominal pain worsened by food intake, and marked decline in mobility and function

Prior to recent hospital stay he was ambulatory short distances. History of CVA in 2009. Patient would like to be able to get out of the bed and spend time sitting in the living room and up in his chair.
Patient presents with B LE and core strength deficits. PT attempted to stand the patient without success but he is able to demonstrated rolling over in bed, moving from supine to sitting at EOB, and ability to scoot along EOB with UE and LE assist. Patient has a hoyer lift but it is not able to fit in his room, he would be able to get the transport chair into the room and with a slide board would be able to transfer into the transport chair to be able to get out of bed and out to the bedroom to spend time in his recliner or other areas in the home sitting.
PT instructed supine and seated HEP activities to improve strength and functional mobility. Patient will benefit from 1 further visit to work on slide board transfers to improve QOL at end of life.

PT GOALS

PATIENT-STATED GOAL: Be able to get out of bed, sit up in chair, possibly perform BSC or toilet transfer

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

Chair to Bed to Chair - 02. Substantial/maximal assistance

Toilet Transfer - 01. Dependent

Wheel 50 ft w 2 Turns - 01. Dependent

Wheel 150 feet - 01. Dependent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 08/17/2026

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 **WILLIAM KERR** 850 N CENTER AVE GAYLORD, MI 49735 NPI 1184695868	**Phone Number** (989) 731-0658 **Fax Number** (989) 731-0681

Physician's Signature and Date Signed

X

WILLIAM KERR, MD
: Date of physician last face-to-face