HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951260

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
1XT2F50QG90	07/31/2026	07/31/2026 - 09/28/2026	861	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Marie Leavesley 1118 BIRCH RD ALPENA, MI 49707	Female	05/11/1954	989-356-2787
	Email Gege1118@outlook.com		**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:
Closed left hip fracture, sequela (S72.002S); Acute respiratory failure with hypoxia (CMS/HCC) (J96.01); Other fracture of left femur, initial encounter for closed fracture (S72.8X2A); Hypoxia (R09.02)	High fall risk due to gait instability and muscle weakness

ICD-10 CM Principal Diagnosis: S72.002S. Fracture of unspecified part of neck of left femur sequela

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
J96.01	Acute respiratory failure with hypoxia	ALBUTEROL 2 puffs every 4 (four) hours as needed for wheezing or shortness of breath. NICOTINE 7 MG patch on the skin daily Patient not taking; Reported on 5/14/2026 NORVASC 5 MG TABLET BY MOUTH EVERY DAY ZESTRIL 40 MG tablet (40 mg total) by mouth daily VITAMIN 1 capsule by mouth daily ASPIRIN 81 MG mg by mouth daily Trelegy Ellipta 100-62.5-25 mcg blister with device inhaler 1 Puff(s) By Mouth Daily UNABLE TO FIND Probiotic Patient not taking; Reported on 5/14/2026
S72.8X2A	Oth fracture of left femur init encntr for closed fracture	
J44.1	Chronic obstructive pulmonary disease w (acute) exacerbation	
J90.	Pleural effusion not elsewhere classified	
D64.9	Anemia unspecified	
E87.1	Hypo-osmolality and hyponatremia	
I10.	Essential (primary) hypertension	
M81.0	Age-related osteoporosis w/o current pathological fracture	
C34.92	Malignant neoplasm of unsp part of left bronchus or lung	
E78.49	Other hyperlipidemia	
K21.9	Gastro-esophageal reflux disease without esophagitis	

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 Ambulation	**Activities Permitted** Up As Tolerated, Walker,
DME & Supplies walker	**Safety Measures** O2 precautions, fall precautions, , walker precautions
Nutrition Z. NO PHYSICIAN-ORDERED DIET	**Allergies** Dilaudid [Hydromorphone]

Advance Directives	Caregiver Status
full code	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	**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.	patient will be responsible for managing treatment patient will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - SN

PT Eval

OT Eval

4 - Recertification

SN CAREPLAN

SN frequency WK1: 1 (07/31/26-08/01/26),WK2: 1 (08/02/26-08/08/26),WK3: 1 (08/09/26-08/15/26),WK4: 1 (08/16/26-08/22/26),WK6: 1 (08/30/26-09/05/26),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: 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

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:full code

08/02/2026 Problems : Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
muscle weakness
B1000 - Vision Deficit

PROCEDURES: Showering : Assist Patient with shower during nursing visit until patient feels safe, cough/deep breathing exercises, incentive spirometer, coordinate/arrange resources for vision-impaired

TEACH PATIENT/CAREGIVER: * 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

SN NARRATIVE

Patient is being admitted today for SN, PT, and OT

Patient is being admitted today for SN, PT, and OT following a hospitalization for closed left hip fracture status post left hip hemiarthroplasty, gait instability, muscle weakness, fall risk, and acute respiratory failure with hypoxia/COPD exacerbation requiring oxygen management.

Patient lives with her husband in a single family home and is ambulating with a walker around the home and needs some assistance with ADLs and cares. Patient has a PMH of COPD with chronic hypoxic respiratory failure and baseline nocturnal oxygen at 1.5 L.
- Recent left hip hemiarthroplasty on 07/16/2026 after left hip/femoral neck fracture.
- Multiple right-sided rib fractures.
- Hypertension, hyperlipidemia, GERD, osteoporosis, dysphagia, obesity (BMI 31), hyponatremia, postoperative anemia, and vitamin D deficiency.
- History of non-small cell lung cancer of the left lung, status post radiation, followed by pulmonology with no recurrence noted in the hospital documentation.
- Former cigarette smoker; quit approximately three years ago after an approximately 53.2 pack-year history.

Patient and husband were greeted upon arrival and were resting in the living room when I arrived. Patient and husbands questions about what each discipline will help with were answered. SOC paperwork were completed along with vitals and assessment. Vitals were all within normal parameters for this patient. Upon assessment patient had an incision to her left hip that was closed with steri strips and was also covered with a silverlon dressing. Directions were unclear for dressing removal. We attempted to call the Dr's office but the office was closed. we tried to call the on call provider but had to leave a message and never heard back. Patient had husband were educated on s/sx of infection and when to seek medical attention. Patient and husband stated understanding of education via verbal feedback. Patient and her husband were informed of future PT and OT eval visits. Patient and her husband stated no further questions or needs upon completion of visit.

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OT CAREPLAN OT frequency WK3: 1 (08/09/26-08/15/26) 08/11/2026 Problems : M1400 - Dyspnea GG0130B1 - Oral Hygiene GG0130C1 - Toileting Hygiene GG0130E1 - Shower/Bathe Self GG0130F1 - Upper Body Dressing GG0130G1 - Lower Body Dressing GG0130H1 - Don/Doff Footwear GG0130A1 - Eating	**OT NARRATIVE** Patient had a L hip hemiarthroplasty 7/16. OT eval found patient to live with supportive husband Mark in one story home with 3 steps to enter and unilateral handrail and dog. Patient has tub shower with 2 GBs and shower chair. OT recommends TTB, however she prefers shower chair. Patient declines practicing shower transfer, OT instructs on side stepping technique to maintain hip precautions, patient understanding and states thats how she does it. OT cautions patient to not use towel rack external shower for support and to replace with durrable GB, which patient is agreeable to. OT recommends to have CG assist for shower transfers and bathing tasks, which she states her husband assists for supervision. Patient has sunken living room with 2 STEPS, she navigates steps with sup using hemiwalker. She completes transfers mod I and prefers to use hemi walker, writer recommends for longer distances in home to use 2WW. Patient requires SUP for dressing, she is knowledgeable about hip precautions and has good safety awareness for maintaining hip precautions. OT EDU on edema management, SS for infection, which patient does not have at this time, incision is covered by steristrips and FU with ORTHO is 8/28. OT EDU on fall prevention and recommended AE to maintain hip precautions with dressing and bathing ADL'S. Patient's BUE AROM AND STRENGTH is WFL. Patient declines continued OT intervention, therefore OT EVAL ONLY.

PT CAREPLAN

PT frequency WK2: 1 (08/02/26-08/08/26),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),WK10: 1 (09/27/26-09/28/26)

09/02/2026 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: Manual Therapy: Manual therapy may include manually resisted or assisted range of motion to the joints of the right or left lower extremity; manual muscle stretching to decrease muscular tension and improve range of motion for improved transfers in and out of vehicle., home exercise program: Therapist to instruct seated, standing and/or reclined home exercises including but not limited to any or all of the following as tolerated: active or band resisted/assisted ankle pumps, circumduction, hip flexion, adduction, and/or abduction, range of motion for Lower extremity joints of knees, hips, and/or ankle/foot. Core strengthening; neuromuscular education. Written home exercises provided and program may be modified and/or progressed as tolerated., 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

Continue with Patty/Daniel weekly.
As of 30 day reassessment, the patient continues make progress toward functional goals, participates in care, and tolerated PT interventions well at today's visit. TUG score improved to 19 sec with 2WW. Ambulation distances improved to approx 150 ft., with improved exercise tolerance demonstrated since start of care. The patient would continue to benefit from continued physical therapy services in order promote greater independence and decrease risk of falls and further hospitalizations. Plan for future visits is to progress therapeutic exercises, transfer and gait training and to update home exercise program. Patient and caregiver to be educated on progress made and realistic goals for PT. Progress has been slowed by medical comorbidities and safety concerns.

PT GOALS

PATIENT-STATED GOAL: Walk without walker

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

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

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

Sit to Stand - 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

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

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 07/31/2026

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: 07/26/2026

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 **CORI WILLIAMS**
105 ARBOR LANE
ALPENA, MI 49707
NPI 1710371877

Phone Number (989) 356-3485

Fax Number (989) 356-6396

Physician's Signature and Date Signed

X

CORI WILLIAMS, NP
07/26/2026: Date of physician last face-to-face