HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951229

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
80027442300	09/03/2026	09/03/2026 - 11/01/2026	962	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Jeffery Walters 11416 Sparr Rd Johannesburg, MI 49751	Male	01/30/1964	(989) 350-6222
	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:
Jeffery is a 62 year old male who is homebound with a DX (J44.9) CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED and (M54.42) LUMBAGO WITH SCIATICA, LEFT SIDE Jeffery has an unsteady gait, poor balance and will need Physical Therapy services and Occupational Therapy for ADL functioning, strengthening, endurance, balance and to promote home safety and education. RN for education and vital monitoring.

Physician Statement on Homebound Status:
Absences from the home require considerable and taxing effort and infrequent or short duration. Absences from the home are for medical or religious reasons only

ICD-10 CM Principal Diagnosis: M54.42. Lumbago with sciatica left side

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
J44.9	Chronic obstructive pulmonary disease unspecified	Tizanidine Hydrochloride - Tizanidine Hydrochloride eq 2 mg base 2 tabs by mouth every 8 hours PRN muscle spasms Metformin - Metformin Hydrochloride 500mg by mouth three times a day WARFARIN 6 MG Oral one time a day for A-fib and DVT Mon, Wed, Fri Warfarin - Warfarin Sodium 5mg by mouth once a day Taken on Tues, thurs, sat Warfarin - Warfarin Sodium 5mg by mouth once a day Taken on Tues, thurs, sat Oxybutynin - Oxybutynin 5mg 1 tab by mouth every 8 hours PRN for bladder spasms
E11.59	Type 2 diabetes mellitus with oth circulatory complications	
I48.20	Chronic atrial fibrillation unspecified	
N40.1	Benign prostatic hyperplasia with lower urinary tract symp	
N13.9	Obstructive and reflux uropathy unspecified	
G89.29	Other chronic pain	
M62.81	Muscle weakness (generalized)	
R33.8	Other retention of urine	

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 Endurance, Ambulation	**Activities Permitted** Walker, Up As Tolerated, , Independent at Home,
DME & Supplies walker,	**Safety Measures** medication safety, , walker precautions, bathroom safety, anticoagulant precautions, bleeding precautions, fall precautions, diabetic precautions, ambulates with device
Nutrition diabetic	**Allergies** no known allergies

Advance Directives	Caregiver Status
Living Will	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 add discharge plan

Orders for Discipline and Treatment:

1 - SOC - SN

OT Eval

PT Eval

4 - Recertification

SN CAREPLAN

SN frequency WK1: 1 (09/03/26-09/05/26),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),WK9: 1 (10/25/26-10/31/26)

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: 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, 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:Living Will

09/03/2026 Problems : M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
muscle weakness
limited strength
limited endurance
diarrhea
abnormal BS < 70/140 > mg/dL

PROCEDURES: Lab Draw: Lab draw on 9/8/26 and PRN for INR pt on 2 different warfarin scripts to achieve proper dose and therapeutic levels, cough/deep breathing exercises: If pt experiencing any SOB, states has occasional SOB, glucose testing via monitor: Pt does not have a monitor, assess s/s of hypo/hyperglycemia and the need to get pt a glucose monitor.

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

SN NARRATIVE

Upon arrival greeted by pt at the door. Pt lives independently, uses a walker when ambulating. Pt states his neighbor is supportive, but no family in the area to assist pt, lives independently. Pt states his friend is remodeling his home. Pt states went into TC hospital on April 14th for 4 days and then transferred to Mcreynolds rehab facility. Discharged home on Tues morning 9/1. Pt states pain 7/10 in back, pt denies any SOB or other concerns. Pt states does not monitor BS, does not even have the diabetic supplies at home, states it stabilizes as long as he continues to take his metformin. VS within normal parameters for pt, assessment completed.

- 08/31/2026 face-to-face documentation identifies the patient as homebound with J44.9 chronic obstructive pulmonary disease and M54.42 lumbago with sciatica, left side. The referral documents unsteady gait and poor balance and orders Physical Therapy and Occupational Therapy for ADL functioning, strengthening, endurance, balance, home safety, and education, plus RN services for education and vital monitoring.
- The 08/31/2026 discharge summary states he was admitted to McReynolds Hall for therapy after hospitalization for weakness, transitioned to long-term care after completing PT/OT, later received repeat therapy for chronic back pain, and was determined safe for discharge. Earlier H&P documentation states the preceding acute-care treatment included emphysematous cystitis, obstructive uropathy, colitis, and alcohol abuse. At SNF discharge he remained clinically stable with chronic back pain and denied shortness of breath, chest pain, abdominal pain, fever, chills, nausea, or vomiting.

Frequency: Once weekly (Discharge instructions state retest INR on 9/8 per doc discharge will need to be RN- pt unsure if we are drawing INR- look for order) AGreeable to OT/PT.
PCP: Dr. Lee

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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, * 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	Upon arrival greeted by pt at the door. Pt lives independently, uses a walker when ambulating. Pt states his neighbor is supportive, but no family in the area to assist pt, lives independently. Pt states his friend is remodeling his home. Pt states went into TC hospital on April 14th for 4 days and then transferred to Mcreynolds rehab facility. Discharged home on Tues morning 9/1. 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Education given on fall risk and importance of using walker when ambulating, especially since pt has no phone or life alert and no means of contacting someone if he falls, pt verbalized understanding. pt states is looking into getting a phone and a life alert device, follow up on this needed, provide the office with phone number when pt receives one. If no life alert ordered by next visit assist pt in acquiring one. VS within normal parameters for pt, assessment completed. - 08/31/2026 face-to-face documentation identifies the patient as homebound with J44.9 chronic obstructive pulmonary disease and M54.42 lumbago with sciatica, left side. 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At SNF discharge he remained clinically stable with chronic back pain and denied shortness of breath, chest pain, abdominal pain, fever, chills, nausea, or vomiting. **SN GOALS** PATIENT-STATED GOAL: Increased strength and mobility, decreased pain GOALS 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 * 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 patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule
	OT NARRATIVE PT participated in an OT eval and home assessment. PT reports he was in the hospital and rehab for approx 5 months. During this time his neighbor came to his house and cleaned it out and fixed what was broken so it was a livable establishment as he had been unable to care for the house and it had been falling in disrepair for the past several years. PT reports that during his hospital and rehab stay the community has reached out with resources for rides, grocery shopping and other community resources. PT reports he is not driving anymore and has a neighbor that will assist for larger IADL tasks such as garbage removal and med pick ups. PT reports he is independent in ADL's such as dressing, grooming, and toileting. He has a commode over the toilet, is ordering a TTB and OT provided safety strips for the floor of shower. PT has also ordered grab bars to be installed at shower. He reports he can get in/out of bed although declined trial. PT is ambulating slowly thru out the home but has a 2ww to use if he feels the need. He did furniture surf at times during eval but did not demonstrate any LOB. PT reports he has not had any falls or near falls since being home. OT offered to make a referral to commission on aging for housekeeping although declined reporting that is how he gets up and moves around. He demonstrated the ability to pick object off the floor with 1 hand on counter to steady him. Both Patient and OT agreed that he is safe in his home with the community resources and no further skilled OT services required at this time.

	PT NARRATIVE Patient was homebound with J44.9 chronic obstructive pulmonary disease and M54.42 lumbago with sciatica, left side. The referral documents unsteady gait and poor balance and orders Physical Therapy and Occupational Therapy for ADL functioning, strengthening, endurance, balance, home safety, and education. Patient reports he is feeling sore today due to chronic low back pain, reporting pinched nerves and bulging discs throughout the low back which has been present for "years and years". Reporting no surgeries for the low back but has been seen by a specialist. Patient reports he has been getting around ok and isn't using the walker over the past few days. Patient reports he was at McReynold's rehab for 5 months beginning with a bladder infection in April . Patient presents with B LE weakness and stability/balance deficits, tinetti 17/28 indicating high fall risk. Minimal difficulty performing sit to stands, and difficulty getting in and out of the tub. He is waiting for his grab bars to arrive and installed before attempting a shower. At this time this patient will benefit from skilled PT interventions to address low back pain, generalized weakness, balance and stability limitations to improve safety in the home and tolerance to usual ADL's. With education and instruction of HEP. **PT GOALS** PATIENT-STATED GOAL: add patient-stated goal GOALS

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 09/03/2026

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: 08/31/2026	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 **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
08/31/2026: Date of physician last face-to-face