HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195830

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
6GR9QY1KX49	08/12/2026	08/12/2026 - 10/10/2026	904	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Kenneth Gauthier 10068 OSSINEKE RD OSSINEKE, MI 49766	Male	06/11/1939	(989) 590-0040
	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:

- Discharged home with home health care after hospitalization for complete heart block/junctional bradycardia, choledocholithiasis, obstructing left ureteral stone, heart failure, COPD, atrial fibrillation, and associated deconditioning. Home care referral orders specify RN, Physical Therapy, and Occupational Therapy for post-op care and difficulty leaving home for required medical services. (Source: Discharge Documents, pp. 9-11; Home Care Referral Order, p. 47) - Hospital course included permanent pacemaker implantation on 08/03/2026 for third-degree AV block, ERCP with sphincterotomy and balloon sweep on 08/04/2026 for choledocholithiasis, and cholecystectomy on 08/05/2026. Warfarin was held for supratherapeutic INR and resumed after cholecystectomy. Obstructing left ureteral stone was managed without acute urologic surgery with outpatient ureteroscopy planned. Patient also had possible acute-on-chronic HFpEF, COPD with intermittent oxygen requirement, and reduced mobility/endurance. (Source: Discharge Documents, pp. 10-11)

Physician Statement on Homebound Status:

medical condition could get worse if patient leaves home

ICD-10 CM Principal Diagnosis: Z48.812. Encntr for surgical aftcr following surgery on the circ sys

Other Pertinent Diagnoses

ICD-10 CM	Description
I44.2	Atrioventricular block complete
I50.32	Chronic diastolic (congestive) heart failure
I48.0	Paroxysmal atrial fibrillation
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs
J44.9	Chronic obstructive pulmonary disease unspecified
K80.50	Calculus of bile duct w/o cholangitis or cholecyst w/o obst
N20.1	Calculus of ureter

Medications

ROBAXIN 500 MG tab(s) by mouth 3 times a day Duration: 4 Days Pickup at SAGINAW VAMC PHARMACY
MIDODRINE HYDROCHLORIDE 5 MG tab(s) by mouth 2 times a day during day Pickup at SAGINAW VAMC PHARMACY
ACETAMINOPHEN 325 MG tab(s) by mouth 2 times a day as needed for Mild Pain or Fever
ALBUTEROL 2 inh inhaled 4 times a day as needed for Wheezing
albuterol-ipratropium (albuterol-ipratropium 2.5 mg-0.5 mg/3 mL inhalation solution) 2.5 MG Milliliter nebulized inhalation Every 6 hours
ASPIRIN 81 MG tab(s) by mouth Every day
ATORVASTATIN 20 MG tab(s) by mouth Every day
budesonide/glycopyrrolate (Breztri Aerosphere 160 mcg-9 mcg/inh inhalation aerosol) 2 puff(s) inhaled 2 times a day rinse mouth and throat after use
BUSPIRONE HCL 10 MG tab(s) by mouth 2 times a day
CINACALCET HYDROCHLORIDE 30 MG tab(s) by mouth 2 times a day
FLUTICASONE 1 spray(s) each affected nostril Every day shake well before using
MULTIVITAMIN 1 tab(s) by mouth Every day
OMEPRAZOLE 20 MG cap by mouth Every day

Z95.0	Presence of cardiac pacemaker	TORSEMIDE 20 MG tab(s) by mouth Every day Duration: 90 Days WARFARIN 5 MG tab(s) by mouth Every Friday

Prognosis fair	**Mental and Psychosocial Status** 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, Hearing, Ambulation	**Activities Permitted** Up As Tolerated, Cane, Independent at Home
DME & Supplies grab bars, bath bench, oxygen supplies	**Safety Measures** medication safety, fall precautions, ambulates with device, anticoagulant precautions, cardiac precautions
Nutrition low sodium	**Allergies** oxyCODONE - Rash

Advance Directives	Caregiver Status
No Advance Directive	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

SN CAREPLAN

SN frequency WK1: 1 (08/12/26-08/15/26),WK2: 1 (08/16/26-08/22/26),WK3: 1 (08/23/26-08/29/26),WK4: 1 (08/30/26-09/05/26),WK5: 1 (09/06/26-09/12/26),WK6: 1 (09/13/26-09/19/26),WK7: 1 (09/20/26-09/26/26),WK8: 1 (09/27/26-10/03/26),WK9: 1 (10/04/26-10/10/26)

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

08/13/2026 Problems : cluttered/soiled living area (CM)
insects/rodents present (CM)
#1 - Observable Surgical Wound - Anterior Left Upper Chest - Pacemaker placed surgical incision
#2 - Observable Surgical Wound - Anterior Midline - Multiple minor surgical incisions on abdomen removal of gallbladder
M1033 - Exhaustion
M1400 - Dyspnea
M2020 - Oral Med Management
dependent edema
limited strength
limited endurance
bruising/discoloration

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Left Upper Chest - Pacemaker placed surgical incision: Keep incision clean and dry. Spray with wound cleanser, leave to air dry., physician-ordered wound care: #2 - Observable Surgical Wound - Anterior Midline - Multiple minor surgical incisions on abdomen removal of gallbladder: Keep incision clean and dry. Spray with wound cleanser, leave to air dry., cough/deep breathing exercises, monitor intake & output, coordinate/arrange for maintenance of clean/uncluttered living area

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory

SN NARRATIVE

Upon arrival greeted by pt sitting in his recliner. Pt on 2L O2 via NC. Pt uses a walker to ambulate. Pt went into Alpena to have heart checked in ER, transferred to hospitalized 7/31-8/8 at Munson TC. Pt had recent surgery-pacemaker placement. Removal of gallbladder. L ureteral stone- pt not feeling any pain. Pt states pain 1/10 around belly button from gallbladder surgery. Pt lives alone, no animals. VS obtained, assessment completed within normal parameters for pt, no further questions.

- Discharged home with home health care after hospitalization for complete heart block/junctional bradycardia, choledocholithiasis, obstructing left ureteral stone, heart failure, COPD, atrial fibrillation, and associated deconditioning. Home care referral orders specify RN, Physical Therapy, and Occupational Therapy for post-op care and difficulty leaving home for required medical services.
- Hospital course included permanent pacemaker implantation on 08/03/2026 for third-degree AV block, ERCP with sphincterotomy and balloon sweep on 08/04/2026 for choledocholithiasis, and cholecystectomy on 08/05/2026. Warfarin was held for supratherapeutic INR and resumed after cholecystectomy. Obstructing left ureteral stone was managed without acute urologic surgery with outpatient ureteroscopy planned. Patient also had possible acute-on-chronic HFpEF, COPD with intermittent oxygen requirement, and reduced mobility/endurance.

Frequency: Once weekly
PCP: Dr. Szymanski f/u appt tomorrow
General Surgery (gallbladder): Ashley Sachtleben f/u in 2 weeks
Heart and vascular (pacemaker): f/u with Neil Shaw on 9/21

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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 achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, 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, insects/rodents not present in the patient's living environment	surgery. Pt lives alone, no animals. VS obtained, assessment completed within normal parameters for pt, no further questions. - Discharged home with home health care after hospitalization for complete heart block/junctional bradycardia, choledocholithiasis, obstructing left ureteral stone, heart failure, COPD, atrial fibrillation, and associated deconditioning. Home care referral orders specify RN, Physical Therapy, and Occupational Therapy for post-op care and difficulty leaving home for required medical services. - Hospital course included permanent pacemaker implantation on 08/03/2026 for third-degree AV block, ERCP with sphincterotomy and balloon sweep on 08/04/2026 for choledocholithiasis, and cholecystectomy on 08/05/2026. Warfarin was held for supratherapeutic INR and resumed after cholecystectomy. Obstructing left ureteral stone was managed without acute urologic surgery with outpatient ureteroscopy planned. Patient also had possible acute-on-chronic HFpEF, COPD with intermittent oxygen requirement, and reduced mobility/endurance. **SN GOALS** PATIENT-STATED GOAL: Pt states increased strength from hospitalization and heal surgical incisions 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 * how to achieve wound healing including cleaning and dressing wound * position changes * skin care * diet modification * record wound measurements * 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 insects/rodents not present in the patient's living environment
	OT NARRATIVE OT EVAL FOUND PATIENT TO LIVE ALONE IN SMALL HOME WITH STEP TO ENTER. PATIENT HAS A WALK IN SHOWER WITH SUCTION GB'S, SHOWER CHAIR. PATIENT HAS BILAT SHOULDER AROM DEFICITS AND BILAT SHOULDER AND ELBOW STRENGTH DEFICITS. SITTING BALANCE IS GOOD. PATIENT SCORED 14/20 ON BARTHEL ASSESSMENT INDICATING MODERATE DEPENDENCY ON ADLS. PATIENT USES A CANE FOR MOBILITY OUTSIDE OF HOME ON UNEVEN GROUND HOWEVER NO AD IN THE HOME, REQUIRES SUP FOR TRANSFERS AND THEREFORE REQUIRES SUP FOR ADLS FOR SAFETY. PATIENT HAS A DAUGHTER WHO LIVES DOWNSTATE AND ASSIST FOR SOME APPOINTMENTS AND COMES UP 1X MONTHLY TO ASSIST WITH HOUSEKEEPING, HE ALSO HAS A FRIEND WHO ASSISTS WEEKLY FOR LAUNDRY AND DISHES. HE REPORTS SURGERY 9/24 FOR STENT FOR KIDNEY STONES. PATIENT REPORTS DECLINE IN R SHOULDER AROM AND STRENGTH AND PRIMARY GOAL FOR RUE STRENGTHENING. RECOMMENDED OT INTERVENTION FOR HEP TEACHING, UB STRENGTHENING, EDU FALL PREVENTION AND ADL/IADL TRAINING, 3 MORE VISITS ADJUSTED AROUND PATIENTS UPCOMING SURGERY AND APPOINTMENTS. UB STRENGTH MMT: R | L SHOULDER FLEX: 4 | 4 SHOULDER EXT: 3+| 4- ELBOW FLEX: 4| 4+ ELBOW EXT: 4- | 4 GRIP STRENGTH: # | #

BALANCE:

STATIC SITTING: GOOD

DYNAMIC SITTING: GOOD

STATIC STANDING:

DYNAMIC STANDING:

ADLS:

UB DRESSING: SBA

LB DRESSING: SBA

GROOMING: SUP

ORAL CARE: SUP

UB BATHING: SBA

LB BATHING: SBA

TOILETING: MOD I

FEEDING: INDEPENDENT

TRANSFERS:

SIT TO STAND: SUP

TOILET: SUP

SHOWER: SBA

BED MOBILITY:

INTERVENTIONS:

EDU ON FALL PREVENTION- RECOMMENDED SECURING EXTENSION CORD IN BEDROOM

INSTRUCTED ON MODIFICATIONS TO IMPROVE ACCESSIBILITY IN KITCHEN

DME RECOMMENDED: GB'S, ELEVATED TOILET SEAT OR OVER THE COMMODE SAFETY FRAME, FALL ALERT, HOWEVER PATIENT NOT INTERESTED.

INSTRUCTED ON BUE HEPS FOR SHOULDER AROM AND STRENGTHENING; PATIENT TOLERATED ALL WELL EXCEPT HAD CREPITUS AND SOME DISCOMFORT WITH HORRIZONTAL ABD/ADD, THEREFORE EXERCISE DISCONTINUED.

ADVISED PATIENT TO FU WITH ORTHO REGARDING SHOULDERS

RECOMMENDED CG FOR HOUSEKEEPING/IADLS, PATIENT STATES HE HAS A FRIEND WHO HELPS WITH SOME HOUSEKEEPING AND IS NOT INTERESTED IN FORMAL CG'S

PT CAREPLAN

PT frequency WK2: 1 (08/16/26-08/22/26),WK3: 1 (08/23/26-08/29/26)

08/17/2026 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: 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 - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent

PT NARRATIVE

1wk 2 with Daniel PT (next visit is DC)
The patient was referred for home physical therapy to address functional deficits related to complete heart block/junctional bradycardia, choledocholithiasis, obstructing left ureteral stone, heart failure, COPD, atrial fibrillation, and associated deconditioning with contributing factors including: Chronic diastolic heart failure/HFpEF, paroxysmal atrial fibrillation on warfarin, CAD status post 2-vessel CABG in 12/2017, COPD, obstructive sleep apnea on CPAP, history of CVA, hyperlipidemia, GERD, PFO, history of left bundle branch block, and tobacco history. Recent hospitalization included complete heart block treated with permanent pacemaker, choledocholithiasis treated with ERCP and cholecystectomy, obstructing left ureteral stone with outpatient urology follow-up planned, supratherapeutic INR, and intermittent hypoxia/home oxygen qualification. The patient lives in a home with steps to enter using hand-hold. The patient demonstrates deficits including decreased strength, balance and safety with transfers and ambulation. Functional testing including Timed Up and Go (TUG) test with result of 24 seconds is consistent with an increased risk of falls. Skilled physical therapy interventions including therapeutic exercises, balance, gait and transfer training are reasonable and necessary to address the above deficits, promote greater independence, and improve function.

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	and Go (TUG) test with result of seconds is consistent with an increased risk of falls. Skilled physical therapy interventions including therapeutic exercises, balance, gait and transfer training are reasonable and necessary to address the above deficits, promote greater independence, and improve function. **PT GOALS** PATIENT-STATED GOAL: Patient Goal GOALS Chair to Bed to Chair - 06. Independent Toilet Transfer - 06. Independent 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

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 08/12/2026

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 **RODNEY SZYMANSKI** 4000 WELLNESS DR MIDLAND, MI 48670 NPI 1780678961	**Phone Number** (844) 832-1956 **Fax Number** (989) 633-5241

Physician's Signature and Date Signed

X

RODNEY SZYMANSKI, MD
: Date of physician last face-to-face