HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951551

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
1015102021V626494	09/10/2026	09/10/2026 - 11/08/2026	1128	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Robert Hurst 450 S NICOLET ST APT 351 MACKINAW CITY, MI 49701	Male	12/24/1948	(231) 301-1611
	Email		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:
Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing care, physical therapy and/or speech therapy.	High fall risk due to gait instability and muscle weakness

ICD-10 CM Principal Diagnosis: I63.512. Cereb infrc d/t unsp occls or stenos of left mid cereb art

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
N40.1	Benign prostatic hyperplasia with lower urinary tract symp	LEXAPRO 10 MG mg oral once daily Take 10 mg by mouth once daily LIPITOR 40 MG mg oral daily Take 40 mg by mouth daily LOTRIMIN 1 % cream topical 2 times daily Apply to affected area 2 times daily MYCOSTATIN unit topical as needed Apply topically as needed (yeast). PATANOL 0.1 % ophthalmic twice a day Administer 1 drop into affected eye(s) 2 (two) times a day. THERAGRAN 1 tablet oral daily Take 1 tablet by mouth daily. VITAMIN unit oral daily Take 100 mcg by mouth daily. ELIQUIS 5 MG mg oral twice daily Take 2 tablets (10 mg total) by mouth twice daily for 7 days, THEN 1 tablet (5 mg total) twice daily thereafter.
R33.8	Other retention of urine	
D62.	Acute posthemorrhagic anemia	
R53.1	Weakness	
M62.81	Muscle weakness (generalized)	
R26.81	Unsteadiness on feet	
Z86.718	Personal history of other venous thrombosis and embolism	
I10.	Essential (primary) hypertension	

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: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes
Functional Limitations Ambulation	**Activities Permitted** Wheelchair, Walker
DME & Supplies walker, wheelchair	**Safety Measures** wheelchair precautions, transfer with assist, ambulates with device, fall precautions, walker precautions
Nutrition Z. NO PHYSICIAN-ORDERED DIET	**Allergies** Patient has no known allergies.

Advance Directives
DPOA-H: his brother

Caregiver Status
1. Non-agency caregiver(s) currently provide assistance; 1. Non-agency caregiver(s) currently provide assistance

Rehabilitation Potential
SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

DISCHARGE PLAN:
SN: patient will be responsible for managing treatment
PT: family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:
SN, PT, OT to eval and treat

SN CAREPLAN

SN frequency WK1: 1 (09/10/26-09/12/26),WK2: 1 (09/13/26-09/19/26),WK3: 1 (09/20/26-09/26/26),WK4: 1 (09/27/26-10/03/26),WK5: 1 (10/04/26-10/10/26),WK6: 1 (10/11/26-10/17/26),WK7: 1 (10/18/26-10/24/26),WK8: 1 (10/25/26-10/31/26),WK9: 1 (11/01/26-11/07/26)

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: 3. Multiple hospitalizations (2

or more) in the past 6 months, 4. Multiple emergency department visits (2 or more) in the past 6 months, 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:DPOA-H: his brother

09/10/2026 Problems : D0700 - Social Isolation
M1600 - UTI
M1610 - Urinary Catheter
M1033 - Exhaustion
M1033 - Exhaustion
M1400 - Dyspnea
M2020 - Oral Med Management
dependent edema
limited strength
meal preparation
D0160 - Depression

PROCEDURES: cough/deep breathing exercises, incentive spirometer, monitor intake & output, catheter change, care & irrigation, coordinate/arrange preparation of missing meals, coordinate/arrange long-term socialization activities, monitor dialysis schedule

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, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * urinary catheter management including how to flush catheter change and wash drainage bags prevent infection including proper handwashing positioning of catheter, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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

SN NARRATIVE

RN arrived to pt apartment to complete start of care. Pt was sitting in dining hall having lunch. Reason for Home Health Referral, Home care referral dated 08/31/2026 lists left acute arterial ischemic stroke, MCA, and orders RN, PT, and OT services. The referral certifies the patient as homebound and identifies high fall risk due to gait instability and muscle weakness requiring contact guard. Full weight bearing is documented. The referral fax notes that the patient currently has Advisa Care, but therapy services are not available and another agency is being sought. Recent hospital history: The patient had severe sepsis with acute organ dysfunction due to a complicated catheter-associated UTI with Pseudomonas and Proteus, plus Proteus bacteremia. The course was complicated by gross hematuria with Foley obstruction/clotting requiring catheter exchange, metabolic encephalopathy, acute renal failure, anemia due to blood loss, and generalized weakness/deconditioning. He was treated with antibiotics, Eliquis was temporarily held for hematuria and later resumed, and his encephalopathy, renal failure, and hematuria improved. He then completed swing-bed PT/OT with marked improvement in conditioning before discharge. RN completed vitals and assessment. Vitals within parameters. Pt denies pain today. Pt has indwelling catheter which is taken care of through pt urologist in Petoskey. Pt had catheter changed on Monday September 7th. Pt state understanding of Catheter care and infection prevention. Pt has dependent edema in bilateral lower legs which he wears compression stockings for to help. Pt is in good spirits and doing well since being home from the hospital. Pt lives in assisted living and states he has many friends and is thankful for the help he receives. Discussed RN will visit pt once weekly. PT and OT will be coming to eval pt. Pt verbalized understanding. No further questions or concerns.

SN GOALS

PATIENT-STATED GOAL: Gain strength and learn how to care for self with indwelling catheter

GOALS
patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* 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
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary catheter management including how to flush catheter
* change and wash drainage bags
* prevent infection including proper handwashing
* positioning of catheter
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule, meal preparation is available to patient for all meals	meal preparation is available to patient for all meals
OT CAREPLAN OT frequency WK2: 1 (09/13/26-09/19/26) 09/16/2026 Problems : M1400 GG0130B1 - Oral Hygiene GG0130C1 - Toileting Hygiene GG0130E1 - Shower/Bathe Self GG0130G1 - Lower Body Dressing GG0130H1 - Don/Doff Footwear GG0130A1 - Eating GG0130F1 - Upper Body Dressing	**OT NARRATIVE** Patient was referred for home health occupational therapy following an ischemic stroke. Patient currently resides in an assisted living facility and receives staff assistance with showering every other day. Patient reports a high level of independence with remaining self-care tasks, including dressing and grooming/hygiene, and reports completing transfers independently and safely from chair, bed, and toilet. Patient is able to prepare simple meals in room, with full meals also provided by the facility. Patient has a fall-alert system available to notify facility staff as needed. Patient has appropriate DME/AE in place, including bathroom grab bars, raised toilet seat, shower chair, handheld showerhead, non-slip/grip surfaces, hospital bed with rail, shoehorn, and reacher. Bilateral upper-extremity strength and ROM are within functional limits with no deficits noted that currently impact ADL performance. During evaluation, patient was educated on fall-prevention strategies, including maintaining clear pathways and exercising caution when navigating thresholds and other environmental transitions. Education was provided regarding adaptive strategies for lower-extremity dressing, including increased use of shoehorn and available adaptive equipment. Patient was also instructed in core engagement during lower-extremity dressing, functional transfers, and sit-to-stand/stand-to-sit transitions to promote stability and safety. Patient demonstrates adequate functional independence, has appropriate DME/AE and facility support in place, and presents with no current skilled OT needs requiring continued intervention. OT evaluation only is appropriate at this time, with no additional occupational therapy visits indicated.

PT CAREPLAN

PT frequency WK1: 1 (09/10/26-09/12/26),WK2: 1 (09/13/26-09/19/26),WK3: 1 (09/20/26-09/26/26),WK4: 1 (09/27/26-10/03/26),WK5: 1 (10/04/26-10/10/26),WK7: 1 (10/18/26-10/24/26),WK9: 1 (11/01/26-11/07/26)

09/19/2026 Problems : GG0170D1 - Sit to Stand
GG0170F1 - Toilet Transfer
GG0170I1 - Walk 10 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170K1 - Walk 150 Feet
GG0170M1 - 1 - Step (curb)
GG0170N1 - 4 Steps
GG0170O1 - 12 Steps
GG0170P1 - Picking Up Object
GG0170G1 - Car Transfer
GG0170E1 - Chair to Bed to Chair
GG0170L1 - Walk 10 ft on Uneven Surface

PROCEDURES: home exercise program: Patient instructed on HEP program, and handout provided; patient demonstrates safety and undrestanding, and good tolerance; handout for: Reclined quad set, and glute sets, each 5-10 reps, hold 5 seconds, 2 sets, 1-3x/day; REclined SLR x5-10, 2-3x/day; seated LAQ x5-10, 2 sets, 1-2x/day; sitting marches 5-10, 2-3x/day; bilat as tolerated; verbal and written instruction to go slow, stop if pain., equipment training: Front-wheel walker, electric scooter, hospital bed, lift chair. Home safety/falls prevention as indicated., work simplification/energy conservation: Pacing to prevent over-exertion and to reduce risk for falls. Education proper mechanics as indicated., gait training/stair training: Gait across even/uneven surfaces with assistive device to maximize safety and independence. Physical Therapy to utilize Therapeutic exercises; therapeutic activities; gait training , balance training, neuromuscular reeducation; pain management to address difficulty walking., transfers training: Functional transfers as required in/out of home and vehicle transfer training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT NARRATIVE

Patient appears to be inconsistent historian at times; says he was receiving home care and doing exercises prior to referral to this agency. Documents in home show Advisacare discharge 9/8 per nomnc.

Therapist spoke with caregiver 9/10 to confirm physcial therapy appointment for 9/11, and she also states patient has appt 9/11 in afternoon.

Patient reports he receives in-home assistance including from caregiver named "Emma".

Patient with Precautions including but not limited to: Fall risk, Forgetful, Foley, DVT on Eliquis, HTN.

Pulse 60, O2 sat 98% room air, 0/10 pain at rest and with activity, Temporal temperature 98.8 deg F, BP 118/62, resp rate 16.

A&O, appears forgetful, has done HH in past. Denies DM; does have custom diabetic-style shoes with insoles.

Says clot RLE from a couple weeks ago and is on blood thinner per patient .

Patient goal is to walk further (currently able to walk to lower level of building to front door and back with assistance; says he walked back from dining room with caregiver yesterday), has to take his time per patient.

Patieint also reports he already walked in hall today. Says since hospital he feels he is actually doing better; though states he wants to continue working on walking. Patient denies any recent falls. No recent/current dizziness. Trace BLE edema, no TED/compression stockings currently on, although noted in room. 2/10 dyspnea with activity.

Tinetti score 12.

Strength 3/5 BLE except Right ankle as noted: RLE with chronic issues per patient; achilles tightness noted; neutral ankle Inversion and 3-/5 strength, WNL Eversion, dorsiflexion 3-/5 strength and -21 degrees dorsiflexion, plantarflexion WNL.

No recent weight available; patient denies being diabetic. Patient denies any allergies.

Patient instructed on HEP program, and handout provided; patient demonstrates safety and undrestanding, and good tolerance; handout for: Reclined quad set, and glute sets, each 5-10 reps, hold 5 seconds, 2 sets, 1-3x/day; REclined SLR x5-10, 2-3x/day; seated LAQ x5-10, 2 sets, 1-2x/day; sitting marches 5-10, 2-3x/day; bilat as tolerated; verbal and written instruction to go slow, stop if pain.

Education on proper use of walker; patient declines scooter today, says no issues with. Says he always has someone with him when utilizing scooter wheelchair. Able to manage controls on lift recliner; no issues hospital bed or power wheelchair per patient. Declines hospital bed today, says gets in and out himself but also has caregiver in AM and PM.

Has doctor appointment this afternoon. Has meals served in dining room; or brought to room, noted to have breakfast in his room this morning.

Educaiton falls prevention strategies including: emergency button (has and is wearing), ensure proper footwear; ensure proper lighting; has nightlighs per patient; remove throw rugs/rugs/tripping hazards; hangs bath mat when not in use; ensure stable chair of proper height with arm rests (as available; good adjustment of lift chair demonstrated); do not rush; stand several seconds prior to moving to ensure steady and not dizzy; pace yourself. Has installed grab bars throughout bathroom. Has nonslip mat for shower. Ensure clear pathways/no clutter.

Reviewed emergency plan due to patient on 3rd floor with elevator access; stairs to exit are near elevator, discussed bumping/scooting on steps technique if required (such as in emergency).

Keeps lamp/phone/controsl in reach, ensure needs in reach beside chair/bedside.

Hangs bath mat when not in use

Has urinal. also has raised toilet seat with handles - not curently utilizing.

Additional equipment in home: front wheel walker, lift reclinerr, scooter wheelchair with lumbar and neck cushions, hospital bed (electric), bedside commode next to bed; padded bedside commode with back over toilet; installed grab bars in restroom, accessible apartment, elevator access, step-in shower, shower seat with back, handheld shower head with lower holder as well, reacher.

Patient indicates facility has some activities he attends.

History of wound at bottom per patient but went away.

Patient reports he has help am and pm daily in/out of bed and with compression stocking(s).

Gait training 80 feet with front-wheel walker and CGA; moderate effort per pateint; BP and vitals stable, 98% O2 sat room air.

Walker too high, education on proper adjustment, patient declines today. cues to stay closer to walker, and keep feet appropraite distance apart due to too far apart/outside walker base of support at times; patient says he knows this as other staff also tell him this. tendency to lean forward when getting too far behind walker. 0.5 gt speed (20 seconds 10 feet). Shoes on, bilat toe out, mild rle ankle valgus/pronation demonstrated with gait.

SBA sit to stand lift chair adjusts independently (although slow to find remote).

No trouble bed mobility per patient; does himself and also has am and pm assist 7 days/week per patient. Hsopital bed is electric adjusting, and has bilateral assist rails.

Patient lives on accessible hallway with 190-200 feet to elevator from his front door.

Left with needs in reach. Aide coming shortly to help to appointment this afternoon per patient.

Per staff at facility, Independent living, with facility (non-clinical) staff present 24/7.

No history of ankle brace per patient. Ankle a little stiff when first starts walking, but denies pain per patient.

Home care referral dated 08/31/2026 lists left acute arterial ischemic stroke, MCA, and orders RN, PT, and OT services. Full weight bearing is documented. The referral fax notes that the patient currently has Advisa Care, but therapy services are not available and another agency is being sought. Recent hospital history: The patient had severe sepsis with acute organ dysfunction due to a complicated catheter-associated UTI with Pseudomonas and Proteus, plus Proteus bacteremia. The course was complicated by gross hematuria with Foley obstruction/clotting requiring catheter exchange, metabolic encephalopathy, acute renal failure, anemia due to blood loss, and generalized weakness/deconditioning. He was treated with antibiotics, Eliquis was temporarily held for hematuria and later resumed, and his encephalopathy, renal failure, and hematuria improved. He then completed swing-bed PT/OT with marked improvement in conditioning before discharge. Included CT head report from 08/08/2026 states there was no CT evidence of acute intracranial abnormality.

MHx also includes: BPH, retention of urine, cerebral infarction,HLD, HTN, generalized muscle weakness, unsteadiness on feet, anemia, right TKA.

8/14-8/28 Mackinaw straits for weakness. Advisacare ended 9/8 per document in home.

History also of Mclaren HH 2024/2025 patient indicates with folders in home.

Patient demonstrates a delcine in fucntional mobility from prior level, with increased difficulty performing gait, transfers and functional mobility; with impairments including decreased strength, decreased balance, decreased posture, and ROM as noted.

Patient to be seen 1w5, 1every2w4 to address gait training, transfer training, functional strength, falls safety/prevention, balance training, energy conservation, fucntional endurance, skin integrity/pressure relief, pain management, and caregiver education; as indicated. patient demonstrates good rehab potential with physical therapy with caregiver support. patient verbalizes agreement to plan of care at this time.

Patient was involved in goal setting and treatment and development of plan of care. Patient consents to treatment.

Therapist left message for Robin Yates around 1:40 p.m 9/11 regarding clarification of Ted/compression stockings and potential VA MSW for follow-up on level of assistance in the home

PT GOALS
PATIENT-STATED GOAL: walk further

GOALS
Sit to Stand - 05. Setup or clean-up assistance

	Chair to Bed to Chair - 05. Setup or clean-up assistance Walk 50 ft with 2 Turns - 04. Supervision or touching assistance Walk 150 Feet - 04. Supervision or touching assistance Car Transfer - 05. Setup or clean-up assistance Walk 10 Feet - 04. Supervision or touching assistance 1 - Step (curb) - 04. Supervision or touching assistance Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: KATIE PROW SN RN on 09/10/2026

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: 08/15/2026	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 **ROBYN YATES** 1105 SIXTH ST TRAVERSE CITY, MI 49684-2345 NPI 1518174101	**Phone Number** (989) 497-2500 **Fax Number** 19893214118

Physician's Signature and Date Signed

X

ROBYN YATES, FNP
08/15/2026: Date of physician last face-to-face