HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951547

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
80042769600	09/01/2026	09/01/2026 - 10/30/2026	792-1	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Sheila Frasier 4107 Sunset Dr Lewiston, MI 49756	Female	09/01/1970	(810) 938-2186
	Email		Primary Language: Eng.

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:

- Patient is planned to discharge home with spouse on 08/31/2026 with skilled nursing and PT/OT services following skilled rehabilitation for a displaced trimalleolar fracture of the right lower leg treated with right ankle external fixator removal and ORIF. Orders direct continuation of current medications and PCP follow-up in 1-2 weeks. Source: Order Summary Report, active orders as of 08/27/2026. - Recent medical course: Patient sustained a fall with displaced trimalleolar fracture of the right lower leg. She underwent right ankle fixator removal and ORIF and continued skilled therapy. On 08/25/2026 she reported doing well without new concerns; exam documented generalized weakness. Nursing documentation on 08/26/2026 noted right ankle postoperative pain, right lower-extremity edema, surgical incision with Ace wrap/splint in place, non-weight-bearing status to the right lower extremity, and need for a slide board for transfers. Source: Provider Note 08/25/2026 and Daily Skilled Nursing Note 08/26/2026.

Physician Statement on Homebound Status:

medical condition could get worse if patient leaves home

ICD-10 CM Principal Diagnosis: S82.851D. Displ trimalleol fx r low leg subs for clos fx w routn heal

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
E11.9	Type 2 diabetes mellitus without complications	ACETAMINOPHEN 500 MG tablet mouth every 6 hours as needed for mild pain ESTRADIOL 0.5 application vaginally every night shift every Tue, Fri apply 1/2 inch to vulva IBUPROFEN 600 MG tablet mouth every 6 hours as needed for mild pain LAMOTRIGINE 100 MG tablet mouth two times a day PANTOPRAZOLE 40 MG tablet mouth one time a day LEVOTHYROXINE 1 tablet mouth one time a day for low thyroid hormone QUETIAPINE FUMARATE 200 MG tablet mouth at bedtime TIZANIDINE HYDROCHLORIDE 2 MG tablet mouth four times a day for muscle relaxant ZOLPIDEM 5 MG tablet mouth at bedtime for difficulty sleeping hypnotic ATORVASTATIN 10 MG tablet mouth at bedtime CALCIUM 500 MG tablet mouth every 8 hours as needed for dyspepsia OXYCODONE 10 MG tablet mouth three times a day PAROXETINE 30 MG tablet mouth one time a day TRAZODONE 100 MG tablet mouth at bedtime give QHS SENNOSIDES 8.6 MG tablet mouth two times a day for constipation CELECOXIB 200 MG capsule mouth two times a day for inflammation
E03.9	Hypothyroidism unspecified	
F31.81	Bipolar II disorder	
M54.12	Radiculopathy cervical region	
M79.7	Fibromyalgia	
G93.32	Myalgic encephalomyelitis/chronic fatigue syndrome	

G47.33	Obstructive sleep apnea (adult) (pediatric)	inflammation TRULICITY 4.5 MG milligram subcutaneously one time a day every Mon ASPIRIN 81 MG tablet mouth two times a day for 2 Weeks

Prognosis good	**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: 2. Sometimes, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes
Functional Limitations Endurance, Ambulation	**Activities Permitted** Wheelchair
DME & Supplies wheelchair, diabetic supplies	**Safety Measures** medication safety, non-weight bearing RLE, bathroom safety, anticoagulant precautions, fall precautions, diabetic precautions, transfer with assist
Nutrition regular	**Allergies** Azithromycin, diphenhydrAMINE, Gabapentin, Penicillin, Depakote, Jardiance, Zithromax

Advance Directives
Full Code (Yes) to Artificial Hydration. (Yes) to Artificial Nutrition (Yes) to Diagnostic Testing. (Yes) to Infection Control Outbreak Testing.

Caregiver Status
1. Non-agency caregiver(s) currently provide assistance; 0. No assistance needed - patient is independent or does not have needs in this area

Rehabilitation Potential
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.

DISCHARGE PLAN:
SN: patient will be responsible for managing treatment
PT: patient will be responsible for managing treatment
OT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

OT Eval

PT Eval

SN CAREPLAN

SN frequency WK1: 1 (09/01/26-09/05/26),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 (10/25/26-10/30/26)

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), 3. Multiple hospitalizations (2

or more) in the past 6 months, 4. Multiple emergency department visits (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:Full Code (Yes) to Artificial Hydration. (Yes) to Artificial Nutrition (Yes) to Diagnostic Testing. (Yes) to Infection Control Outbreak Testing.

09/21/2026 Problems : #1 - Non-Observable Surgical Wound - Anterior Right Ankle - Non observable due to ace wrap- orders to remain on, do not remove.
M1720 - Anxiety
D0700 - Social Isolation
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
dependent edema
balance deficit
muscle weakness
limited strength
limited endurance
heartburn/indigestion
bruising/discoloration
abnormal thyroid <> 0.40 - 4.50 mIU/mL

SN NARRATIVE

PCP: Dr. Ellen Buckner Lewiston Munson

F/u currently scheduled for the 9th, pt has to call and reschedule, unable to make that visit, husband can't take her that day.

Pt requests visits after 9:30am

Upon arrival greeted by daughter, pt still sleeping. Daughter woke up pt and wheeled her mother to her recliner. Non weight bearing on R leg, has C collar until end of September. Lives in home with daughter and husband- very supportive, 1 dog. Pain 3/10, occasionally stabbing pain 5/10 RLE. VS obtained, assessment completed, no further concerns.

- Patient is planned to discharge home with spouse on 08/31/2026 with skilled nursing and PT/OT services following skilled rehabilitation for a displaced trimalleolar fracture of the right lower leg treated with right ankle external fixator removal and ORIF. Orders direct continuation of current medications and PCP follow-up in 1-2 weeks. Source: Order Summary Report, active orders as of 08/27/2026.

- Recent medical course: Patient sustained a fall with displaced trimalleolar fracture of the right lower leg. She underwent right ankle fixator removal and ORIF and continued skilled therapy. On 08/25/2026 she reported doing well without new concerns; exam documented generalized weakness. Nursing documentation on 08/26/2026 noted right ankle postoperative pain, right lower-extremity edema, surgical incision with Ace wrap/splint in place, non-weight-bearing status to the right lower extremity, and need for a slide board for transfers. Source: Provider Note 08/25/2026 and Daily Skilled Nursing Note 08/26/2026.

SN GOALS

PATIENT-STATED GOAL: Pt states heal RLE, Remove C collar, and increased strength and mobility.

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
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* 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

abnormal BS < 70/140 > mg/dL
D0160 - Depression

PROCEDURES: physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Right Ankle - Non observable due to ace wrap- orders to remain on, do not remove.: Currently non removable dressing ACE wrap on RLE, do not remove. If loose can be unwrapped and rewrapped., C Collar: Remain in place, except when showering. Pt states should be removed by end of Sept., cough/deep breathing exercises, glucose testing via monitor, coordinate/arrange long-term socialization activities

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, * 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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, * 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, * strategies to increase socialization, 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/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

OT CAREPLAN

OT frequency 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)

09/09/2026 Problems : Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
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

PROCEDURES: cough/deep breathing exercises, incentive spirometer, wheelchair training, home exercise program: Left UE ROM and gravity eliminated exercises to increase use of LUE, equipment training, work simplification/energy conservation, transfers training

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, * 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, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, 1 - Step (curb) - 02. Substantial/maximal assistance, 12 Steps - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Car Transfer - 05. Setup or clean-up assistance, Picking Up Object - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent

OT NARRATIVE

PT participated in OT eval and home assessment. PT has been in rehab facility for several months following a cervical surgery, came home and fell in the bathroom from dizziness after returning home and resulted in fx ankle. She is now WBAT on right but just found that out the day prior. She is currently using a wheelchair and was allowing dtr or spouse to push her around. PT only has approx 50 % use in left UE secondary to pinched nerves from before neck sx. Dr does not have her on any precautions for movement and is able to use it lightly. PT has a commode and spouse was acquiring a shower chair and HHSH. OT and PT went to bathroom to trial toilet transfer and edu on shower tf. Screw in grab bar highly recommended to increase safety. EDU provided on how to utilize equ together with assist of 2 at first for tf. EDU on other tf within home such as toilet and recliner. OT edu on use of standard walker and dtr obtained one from the garage to trial. PT felt very safe using it during a trial tf to recliner. HEP for LUE provided and completed with pt. ROM listed within note. Pts hope is to use toilet and shower with increased independence and start doing a little something around the home. PT is agreeable to 1 visit a week for 3 weeks and then a reassessment

OT GOALS

PATIENT-STATED GOAL: PT will complete showering from unable to Mod A in 30 day;PT will transfer to toilet with SBA from MOd a in 30 days

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 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

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

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

1 - Step (curb) - 02. Substantial/maximal assistance

12 Steps - 02. Substantial/maximal assistance

4 Steps - 02. Substantial/maximal assistance

Car Transfer - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Oral Hygiene - 06. Independent

	Shower/Bathe Self - 03. Partial/moderate assistance Upper Body Dressing - 05. Setup or clean-up assistance Lower Body Dressing - 05. Setup or clean-up assistance Don/Doff Footwear - 05. Setup or clean-up assistance Wheel 50 ft w 2 Turns - 06. Independent Picking Up Object - 02. Substantial/maximal assistance Toileting Hygiene - 06. Independent Eating - 06. Independent Wheel 150 feet - 06. Independent Walk 10 Feet - 02. Substantial/maximal assistance Walk 150 Feet - 02. Substantial/maximal assistance Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

PT CAREPLAN

PT frequency 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 (10/25/26-10/30/26)

09/16/2026 Problems : GG0170D1 - Sit to Stand
GG0170F1 - Toilet Transfer
GG0170R1 - Wheel 50 ft w 2 Turns
GG0170S1 - Wheel 150 feet
GG0170M1 - 1 - Step (curb)
GG0170O1 - 12 Steps
GG0170N1 - 4 Steps
GG0170G1 - Car Transfer
GG0170P1 - Picking Up Object
GG0170I1 - Walk 10 Feet
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170K1 - Walk 150 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170E1 - Chair to Bed to Chair

PROCEDURES: wheelchair training, home exercise program: AROM, ther ex, ther activity, standing WBAT activities to progress ambulation., therapeutic exercises: B LE strengthening, standing balance activities WBAT, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 04. Supervision or touching assistance, Chair to Bed to Chair - 04. Supervision or touching assistance, Wheel 50 ft w 2 Turns - 06. Independent, Wheel 150 feet - 06. Independent, 1 - Step (curb) - 02. Substantial/maximal assistance, 4 Steps - 02. Substantial/maximal assistance, Walk 10 Feet - 02. Substantial/maximal assistance, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, Walk 150 Feet - 02. Substantial/maximal assistance, Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

PT NARRATIVE

Patient sustained a fall with displaced trimalleolar fracture of the right lower leg. She underwent right ankle fixator removal and ORIF and continued skilled therapy. On 08/25/2026 she reported doing well without new concerns; exam documented generalized weakness. She is now weight bearing as tolerated and wearing the boot most of the day, only removing it occasionally while resting or elevating. She reports she has only been able to tolerate TTWB as of recently and has not attempted standing or walking with a walker.

Patient was previously seen following a cervical fusion and patient reports she is still having difficulty with the left shoulder being painful and limited ROM. Being toe touch weight bearing in the R LE she has to rely on her UE more which has stirred up left shoulder pain. Patient reports she has had a lot of all over achiness. Reporting initially she was having a lot of difficulty with transfers while non weight bearing but has improved with time and new toe touch weight bearing status she is able to perform standing pivot transfers independently. Pain rating at evaluation is 2/10.

Patient presents with right ankle pain and limited weight bearing. Unable to walk at this time but has been cleared to WBAT and needs instruction and guidance to begin walking and standing and transition away from the wheelchair. PT instructed initial HEP to include standing at kitchen sink with increased WB and sit to stands to kitchen sink. Patient will benefit from further skilled PT interventions to address ankle mobility, transfers, standing tolerance and return to ambulation with walker, boot and WBAT.

PT GOALS

PATIENT-STATED GOAL: Be able to walk again, return to PLOF

GOALS
1 - Step (curb) - 02. Substantial/maximal assistance

4 Steps - 02. Substantial/maximal assistance

Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance

Sit to Stand - 04. Supervision or touching assistance

Chair to Bed to Chair - 04. Supervision or touching assistance

Wheel 50 ft w 2 Turns - 06. Independent

Wheel 150 feet - 06. Independent

Walk 10 Feet - 02. Substantial/maximal assistance

Walk 150 Feet - 02. Substantial/maximal assistance

Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 09/01/2026

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: 08/27/2026

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 **ELLEN BUCHLER**
1321 SOUTH MT TOM ROAD
MIO, MI 48647
NPI 1598063299

Phone Number (989) 344-5820

Fax Number 12313927338

Physician's Signature and Date Signed

X

ELLEN BUCHLER, FNP
08/27/2026: Date of physician last face-to-face