HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951552

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
124476890	09/03/2026	09/03/2026 - 11/01/2026	966	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Sherry Johnson 515 N LAKE ST EAST JORDAN, MI 49727	Female	03/09/1954	(248)709-0202
	Email: SHERRYJOHNSON0915@GMAIL.COM		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:	Physician Statement on Homebound Status:
CERVICAL MYELOPATHY SPINAL CORD COMPRESSION	medical condition could get worse if patient leaves home

ICD-10 CM Principal Diagnosis: Z48.811. Encntr for surgical aftcr fol surgery on the nervous sys

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
M48.02	Spinal stenosis cervical region	ALBUTEROL 90 mcg/inh aerosol inhaler, 180 mcg, 2 puffs inhalant Q6H, PRN DULOXETINE HYDROCHLORIDE 30 mg, 1 cap Oral QAM Not taking FERROUS CITRATE FE 59 325 mg (65 mg elemental iron) oral tablet, 325 mg, Oral Q OTHER Day FOLIC ACID 1 mg oral tablet, 1 mg, 1 tabs Oral QHS GABAPENTIN 300 mg oral capsule, 600 mg, 2 cap Oral BID MIRALAX 17 g Oral Daily, PRN PROTONIX 40 mg oral delayed release tablet, 40 mg, 1 tabs Oral BID TYLENOL 650 mg oral tablet, extended release, 1300 mg, 2 t Oral Q8H, PRN ZANAFLEX 4 mg oral capsule, 4 mg, 1 cap Oral BID, PRN ATORVASTATIN 40 mg, 1 tabs Oral QHS METOPROLOL 25 mg oral tablet, extended release, 25 mg, 1 tabs Oral QAM XARELTO 20 mg oral tablet, 20 mg, 1 tabs Oral QHS MOVANTIK 25 mg oral tablet, 25 mg, 1 tabs Oral QAM, PRN Ozempic 8 mg/3 mL (2 mg dose) subcutaneous solution, 2 mg SubCutaneous WEEKLY ZyTEC 10 mg oral tablet, 10 mg, 1 tabs Oral QAM Not taking Acetaminophen: Oxycodone Hydrochloride - Acetaminophen: Oxycodone Hydrochloride 10 mg by mouth every 4-6 hours
G95.9	Disease of spinal cord unspecified	
N18.4	Chronic kidney disease stage 4 (severe)	
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	
I35.1	Nonrheumatic aortic (valve) insufficiency	
I48.91	Unspecified atrial fibrillation	
I47.10	Supraventricular tachycardia unspecified	

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** Walker
DME & Supplies walker	**Safety Measures** fall precautions, walker precautions
Nutrition regular	**Allergies** Fosamax (Hallucinations), ketamine (Hallucinations)

Advance Directives
O

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

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

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

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: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 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:O

09/03/2026 Problems : M1400 - Dyspnea
M2020 - Oral Med Management
abnormal blood pressure
muscle weakness
B1000 - Vision Deficit

PROCEDURES: Pain management : Monitor pain during visit. Educate patient on no medicinal means of pain management (Ice, heat, distractions.), Incision management : Monitor for s/sx of infection and bleeding. Keep dressing on until follow up visit with surgeon. Inform provider of on increased pain or bleeding at surgical site., cough/deep breathing exercises, incentive spirometer, coordinate/arrange resources for vision-impaired

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 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 following C3-C6 posterior cervical surgery for cervical myelopathy and spinal cord compression. On 08/28/2026, the patient underwent posterior cervical arthrodesis at C3-4, C4-5, and C5-6; bilateral laminectomy and medial facetectomy at C3-4, C4-5, and C5-6; and posterior cervical instrumentation from C3 through C6.

SN frequency: Once a week and can be LPN or RN

Patient lives with her husband in a single family home. Patient is up SBA from husband and needs some assistance with ADLs and Cars d/t C collar. Patient has a PMH of Cervical myelopathy, cervical spinal stenosis, spinal cord compression, chronic neck/shoulder pain, lumbar spinal stenosis, and prior spinal cord injury from a 2009 fall are documented.

- Chronic pain and opioid dependence/opioid use disorder are managed with Suboxone. PCP documentation states a baseline Suboxone regimen of 16 mg daily before surgery.

- Recurrent lower-extremity DVT with lifelong anticoagulation on Xarelto; history of multiple CVAs/cerebral infarction. PCP documentation notes persistent left-sided weakness after prior CVA.

- Coronary artery disease, paroxysmal SVT, unspecified atrial fibrillation, moderate aortic stenosis/aortic regurgitation, hypertension, history of orthostatic hypotension/syncope, and implantable loop recorder.

- Chronic kidney disease documented as stage IV in the hospital assessment, with later inpatient renal function described as in the stage 3 range.

- COPD, GERD, gastroparesis, iron deficiency anemia, hyperlipidemia, chronic hepatitis C, prediabetes, degenerative joint disease, and nicotine vaping are documented.

Patient and husband were greeted upon arrival and patient was sittng in recliner in the living room when I arrived. Vitals and assessment were completed. Vitals were all within normal parameters for this patient. Upon assessment patient had a C collar on. C Collar was removed for dressing assessment. Slight shadowing was noted to the dressing on the posterior neck dressing and patient had a small dressing to the right lateral side of the neck with no shadowing noted. SOC paperwork was completed. Patient and husband were informed of s/sx of infection to watch out for. Patient and husband stated understanding of education via verbal feedback. Patient and husband were informed of future PT and OT eval visits and stated no further questions or needs upon completion of visit.

SN GOALS

PATIENT-STATED GOAL: Get strong and increase independence

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 keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

OT CAREPLAN	OT NARRATIVE
OT frequency WK3: 1 (09/13/26-09/19/26) 09/14/2026 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 GG0130F1 - Upper Body Dressing GG0130G1 - Lower Body Dressing GG0130H1 - Don/Doff Footwear GG0130A1 - Eating	PT participated in OT eval and home assessment this date. PT recently had neck fusion and is in neck brace. PT experiencing a few issues of pain in abdominal region secondary to lovenox shots that have to be given for 2 weeks following surgery. They have spoke with Dr about this just prior to my visit as well as pain in upper neck and shoulder region. Dr office reported that they had to move muscles around for sx and to be expected. OT recommended ice therapy and possibly followed by heat. Schedule of icing and heat discussed with pt verbalizing understanding. PT is able to dress LB independently from sitting and requires min a for UB secondary to neck brace. She is able to shower with min to mod a from sig other, with walk in shower, properly installed grab bars at entrance and side wall. PT has a shower chair with arms and back. PT using a 4ww to ambulate thruout the home with extra time. She was able to get herself out of hospital bed and ambulate to kitchen to obtain items. Toilet has toilet rails and she also has a commode set up bedside for night time use. PT demonstrated good safety awareness and reports no issues with memory. SO is able to care for all needs of home. OT edu pt on healing process and keeping brace on the entire time it was prescribed. Falls prevention edu provided although there are no blaring safety issues in home. PT has clear paths, appropriate grab bars and railing at steps. Equ is set up and PT using appropriately. No further skilled OT services indicated follow initial EDU on falls prevention and home safety. PT was agreeable.

PT CAREPLAN
PT frequency WK3: 1 (09/13/26-09/19/26)

09/22/2026 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, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 03. Partial/moderate 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, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 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
On 08/28/2026, the patient underwent posterior cervical arthrodesis at C3-4, C4-5, and C5-6; bilateral laminectomy and medial facetectomy at C3-4, C4-5, and C5-6; and posterior cervical instrumentation from C3 through C6. PT and OT documented postoperative pain, weakness/deconditioning, impaired mobility, and assistance needs with ADLs, with discharge recommendations of rehab versus home health and home occupational therapy versus post-acute rehabilitation.

Patient was previously independent in the home without use of AD or any limitation. Patient has a history of 4 CVA's but reports she gained full function and mobility following the stokes. Patient has a history of low back pain and has difficulty with prolonged walking without her walker.

PT instructed scapular squeezes and UE reaches, and icing to address the pain in the scapular region. PT reviewed continued use of neck immobilizer as instructed, keeping it clean, and signs and symptoms to report to HHA or surgeon.

Patient is safely transfering sit to stand from various surfaces, ambulation with 4ww is good and she is using the walker safely throughout the home. Patient is needing assist from her SO due to neck immobilizer but is slowly regaining independence with ADL's. At this time the patient does not require further skilled PT services and will be beginning out patient PT once restrictions are lifted.

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

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

Toilet Transfer - 03. Partial/moderate 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

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Car Transfer - 05. Setup or clean-up assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAVANNAH GRANDCHAMP SN RN 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: 09/01/2026

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 **Samuel Dyste**
601 BRIDGE ST
East Jordan, MI 49727
NPI 1902098395

Phone Number (231) 536-2206

Fax Number (231) 536-9864

Physician's Signature and Date Signed

X

Samuel Dyste, PA
09/01/2026: Date of physician last face-to-face