

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951566

Patient Details				
Patient's HI Claim No. H79104191	Start of Care Date 07/13/2026	Certification Period 09/11/2026 - 11/09/2026	Medical Record No. 807	Provider No. 239350
Patient's Name and Address Alexis Waldorf 46 SATURN AVE CHEBOYGAN, MI 49721		Gender Female	Date of Birth 01/30/1955	Phone Number (231)420-2383
		Email		Primary Language
Clinical Profile				
Provider's Name Evergreen Home Health		Address 403 W Main Street Suite A1 Gaylord, MI 49735		Phone Number 989-214-1114
NPI 1184225021				Fax Number 866-410-7843
Clinical Condition Requiring Homecare: Cellulitis		Physician Statement on Homebound Status: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home		
ICD-10 CM Principal Diagnosis: L03.115. Cellulitis of right lower limb				
Other Pertinent Diagnoses				
ICD-10 CM	Description	Medications		
L03.116	Cellulitis of left lower limb	Bupropion Hydrochloride - Bupropion Hydrochloride 150 mg/ 1 tablet by mouth once a day every 24 hours Carvedilol - Carvedilol 12.5 mg / 1 tablet by mouth twice a day Cephalexin - Cephalexin eq 250 mg base 2 tablets by mouth every 6 hours 2 Tabs Q6hrs Furosemide - Furosemide 40 mg 1 tablet by mouth twice a day Gabapentin - Gabapentin 100 mg 1 capsule by mouth three times a day Tramadol Hydrochloride - Tramadol Hydrochloride 50 mg / 1 tablet by mouth every 8 hours Trazodone Hydrochloride - Trazodone Hydrochloride 100 MG / 1 Tablet by mouth at bedtime Duloxetine Hydrochloride - Duloxetine Hydrochloride 60 mg / 1 capsule by mouth once a day Pantoprazole Sodium - Pantoprazole Sodium 20 mg 20 MG / 1 Tablet by mouth once a day Aspirin 81Mg - Aspirin 81 mg / 1 capsule by mouth in the morning FERROUS CITRATE FE 59 325 mg / 1 tablet by mouth once a day Atorvastatin Calcium - Atorvastatin Calcium 80 mg / 1 tablet by mouth at bedtime Eliquis - Apixaban 5 mg / 1 tablet by mouth twice a day		
I89.0	Lymphedema not elsewhere classified			
L97.919	Non-prs chronic ulc unsp prt of r low leg w unsp severity			
L97.929	Non-prs chronic ulc unsp prt of l low leg w unsp severity			
I50.32	Chronic diastolic (congestive) heart failure			
I48.0	Paroxysmal atrial fibrillation			
J96.11	Chronic respiratory failure with hypoxia			
I27.20	Pulmonary hypertension unspecified			
Prognosis good		Mental and Psychosocial Status COGNITION: 1. When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer, ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:		
Functional Limitations Ambulation		Activities Permitted Walker		
DME & Supplies wound care supplies, walker		Safety Measures fall precautions, walker precautions, O2 precautions		
Nutrition Z. NO PHYSICIAN-ORDERED DIET		Allergies Toxoid For Booster Use Only (Swelling of arm, Swelling of throat), sulfa drugs (Nausea, Swelling of throat)		
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Advance Directives Living Will	Caregiver Status 0. No assistance needed - patient is independent or does not have needs in this area
Rehabilitation Potential SELF-CARE: , MOBILITY:	DISCHARGE PLAN: SN: patient will be responsible for managing treatment
Orders for Discipline and Treatment: SN TO EVAL AND TREAT	
SN CAREPLAN SN frequency 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 < 50 > 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: 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 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 resummptions 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 09/22/2026 Problems : #1 - Open Wound - Anterior Right Ankle - #2 - Open Wound - Anterior Left Ankle - M1720 - Anxiety D0700 - Social Isolation M1610 - Urinary Incontinence Pain Effect on Sleep Pain Interference with ADLs M1400 - Dyspnea M2020 - Oral Med Management D0160 - Depression dependent edema swell/redness surround. skin open sores/lesions rough/scaly/cracked skin limited strength PROCEDURES: physician-ordered wound care: #1 - Open Wound - Anterior Right Ankle -: RN to complete wound care to bilateral lower legs by cleansing with wound cleanser, applying ABD pad, gauze wrap, and tape, physician-ordered wound care: #2 - Open Wound - Anterior Left Ankle -: RN to complete wound care to bilateral lower legs by cleansing with wound cleanser, applying ABD pad, gauze wrap, and tape, cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: RN to complete wound care to bilateral lower legs by cleansing with wound cleanser, applying ABD pad, gauze wrap, and tape, bladder training, 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	SN NARRATIVE Upon arrival to pt home RN was greeted by pt who was sitting at kitchen table. RN to complete recertification. Pt was in good spirits. Pt feels she is doing well and feels positive about her wounds on bilateral lower legs healing well. RN to complete vitals, assessment, and wound care. Wound care was completed by cleansing wound, applying gauze, ABD pad, and wrapping with gauze roll. Pt tolerated well. Vitals within normal parameters. Pt denies pain. Pt moves freely and independently throughout home using walker. Pt is independent and is able to do wound care as needed on bilateral lower legs. Pt will be seeing SN once weekly for continued wound care. Discussed plan of care with pt, verbalized understanding. No further questions or concerns. SN GOALS PATIENT-STATED GOAL: Heal bilateral lower leg wounds and get stronger 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 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 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 * urinary incontinence management including bladder training * Kegel exercises * skin care * 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

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, * urinary incontinence management including bladder training Kegel exercises skin care, 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

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Signature and Date of Verbal SOC Where Applicable: Electronically signed by: ALEXIS ABRAHAM SN RN on 09/08/2026	
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: 07/09/2026	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 ANDREW CHANG 1500 E MEDICAL CENTER DR ANN ARBOR, MI 48109-5000 NPI 1649286816	Phone Number (734) 936-4000 Fax Number 17346152656
Physician's Signature and Date Signed X ANDREW CHANG, MD 07/09/2026: Date of physician last face-to-face	
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