HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 11951567

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
124324903	07/16/2026	09/14/2026 - 11/12/2026	822	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Mary Lockhart 66 HALF N MOUNT TOM RD MIO, MI 48647	Female	07/02/1950	(989) 346-0041
	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: CVA	**Physician Statement on Homebound Status:** Symptoms identified support difficulty to leave home for medical services required.	

ICD-10 CM Principal Diagnosis: I63.9. Cerebral infarction unspecified

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
I10.	Essential (primary) hypertension	ESOMEPRAZOLE MAGNESIUM 40 mg Oral Daily, PRN delayed-release capsule, 1 Cap FUROSEMIDE 20 mg Oral Daily oral tablet, 1 Tab LOSARTAN POTASSIUM 50 mg Oral daily MONTELUKAST SODIUM 10 mg Oral Daily oral tablet, 1 Tab ROSUVASTATIN CALCIUM 20 mg Oral Daily oral tablet, 1 Tab VENTOLIN 90 mcg/inh inhalation aerosol q4hr, PRN 2 Puff, inh AMLODIPINE 2.5mg/0.5 tab Oral daily OTC STOOL SOFTENER 1-2 tab by mouth as directed See Instructions albuterol/ipratropium 2.5 mg-0.5 mg/3 mL inhalation solution QID, PRN 3 mL, NEB fluticasone/salmeterol 500 mcg-50 mcg/inh inhalation powder BID 1 Puff, INH
J44.9	Chronic obstructive pulmonary disease unspecified	
N39.0	Urinary tract infection site not specified	
K21.9	Gastro-esophageal reflux disease without esophagitis	
R26.81	Unsteadiness on feet	
R47.1	Dysarthria and anarthria	

Prognosis	Mental and Psychosocial Status
good	COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: 2. On awakening or at night only, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:
Functional Limitations Ambulation, Endurance	**Activities Permitted** Up As Tolerated, Walker
DME & Supplies grab bars, walker, bath bench	**Safety Measures** walker precautions, medication safety, bathroom safety, standard precautions, fall precautions
Nutrition Z. NO PHYSICIAN-ORDERED DIET	**Allergies** aspirin!codeine, Keflex

Advance Directives	Caregiver Status
No Advance Directive	1. Non-agency caregiver(s) currently provide assistance
Rehabilitation Potential SELF-CARE: , MOBILITY:	**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 AND PT TO EVAL AND TREAT

SN CAREPLAN

SN frequency WK2: 1 (09/20/26-09/26/26),WK4: 1 (10/04/26-10/10/26),WK6: 1 (10/18/26-10/24/26),WK8: 1 (11/01/26-11/07/26),WK9: 1 (11/08/26-11/12/26)

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), 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 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:No Advance Directive

09/10/2026 Problems : swelling in the arms/legs
dizziness/syncope
balance deficit

PROCEDURES: cough/deep breathing exercises, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, related medication(s) purpose, schedule, * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * 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 dementia coping strategies for the caregiver*, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule

SN NARRATIVE

RN was greeted at front door by patient's daughter. Joined patient in living room. Re-introduced self to patient. Informed her that this visit is for recertification. Head to toe assessment completed and vitals obtained. Vitals stable. Patient has been feeling fatigued during the day. RN asked if she snored. Her daughter stated she snores and gasps for air. RN explained that this could be sleep apnea and recommended patient ask PCP about an eval for OSA. Patient agreeable. Patient states she had a dizzy spell "a few days ago". She did somewhat recently started losartan as a new med. RN recommended patient check blood pressure at least daily. Her daughter stated the blood pressure machine they bought might be defective because it keeps reading "error". RN educated on proper use, including lining up line on cuff with artery. An accurate blood pressure reading was then able to be obtained. Patient stated she got a call last week from a doctor's office letting her know to stop taking her Plavix. She was unable to remember who called her. RN called PCP to verify, and they stated they did elect to stop her Plavix per current guidlines post-CVA. RN updated patient. Patient is agreeable with every other week visits. Patient denied further questions or concerns at conclusion of visit.

SN GOALS

PATIENT-STATED GOAL: become more independent at home again

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 dementia
* coping strategies for the caregiver* 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/caregiver recalls
* lifestyle modifications to manage cardiac condition including symptom management
* diet changes
* regular exercise
* getting enough sleep
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to take the patient's blood pressure
* record the reading
* recalls related medication(s) purpose, schedule

PT CAREPLAN
PT frequency WK1: 1 (09/14/26-09/19/26),WK2: 1 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26),WK6: 1 (10/18/26-10/24/26),WK7: 1 (10/25/26-10/31/26),WK8: 1 (11/01/26-11/07/26)

PROCEDURES: home exercise program: piriformis stretch, standing hip abd, standing hip ext, marches, sit to stand, 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, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent

PT NARRATIVE
Pt presents with improved BLE strength, gait, ability to perform ADLs and function. Pt presents with deficits still in BLE strength, walking tolerance, gait, ability to perform ADLs and function. Pt ambulates with occasional lack of heel strike on IC on RLE, and antalgic gait pattern. Pt presents with increased antalgic gait with prolonged walking. Pt is going to commission on aging to get a rollator walker for prolonged walks. Pt will benefit from continued skilled PT to improve ability to perform ADLs, gait and walking tolerance.

PT GOALS
PATIENT-STATED GOAL: be able to walk > 10 mins without sitting down

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

12 Steps - 06. Independent

Picking Up Object - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SYDNEY STRICKLER 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: 07/15/2026

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 **ALEXIS ATWELL**
1910 E MILLER RD
FAIRVIEW, MI 48621
NPI 1417646571

Phone Number (989) 848-5644

Fax Number (989) 318-4606

Physician's Signature and Date Signed

X

ALEXIS ATWELL, PA-C
07/15/2026: Date of physician last face-to-face