

Home Health Certification and Plan of Care				Order ID: 1184/236	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
5DG9YC0HT20		10/17/2024		From: 10/12/2025 To: 12/10/2025 1377	
6. Patient's Name and Address				7. Provider's Name, Address and Telephone Number	
Curtis Bahe 13820 S 44TH ST APT. 1054, PHOENIX, AZ 85044- 5053399752				Devotion Home Health Care, LLC 11201 N Tatum Blvd, Suite 300 Phoenix, AZ 85028-6039 480-415-4423 1457998957	
8. DOB 01/21/1975 9.Sex Male				10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
11. ICD	Principal Diagnosis		Date	Insulin - Insulin Pork 100 Unit/ML subcutaneous three times a day 15 units subQ injection T1D with meals for diabetes Basaglar - Insulin Glargine 100 Unit/ML subcutaneous at bedtime Insulin Glargine Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML 40 units subQ injection QHS for diabetes Metformin Hcl - Metformin Hydrochloride 500 mg tablets by mouth twice a day 2 Tab(s) PO BID for diabetes Tramadol Hcl - Tramadol Hydrochloride 50 mg by mouth as necessary traMADol HCl Oral Tablet Disintegrating 50 MG High Risk 1 Tab(s) PO Q8HR PRN pain Vit D - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpantenol: Folic Acid: Niacinamide: Pyridox 1.25 MG , 1cap by mouth once a week Cholecalciferol Oral Capsule 1.25 MG (50000 UT) 1 Cap(s) PO weekly with food Simvastatin - Simvastatin 40 mg 1 tab by mouth at bedtime 1 Tab(s) PO QHS Fiber - Benefiber 1 scoop by mouth twice a day Lactulose - Lactulose 10gm/15ml 15 ml by mouth as necessary lactulose 10gm/15ml - take 15 ml PO daily prn constipation Senna - Senna 8.6 mg tablets by mouth as necessary senna 8.6 mg tablet-take 2 tablets PO QHS prn constipation	
Z48.815	Encntr for surgical afctr following surgery on the dgstv sys		10/17/24		
13. ICD	Other Pertinent Diagnoses		Date		
L89.214	Pressure ulcer of right hip stage 4		10/17/24		
L89.159	Pressure ulcer of sacral region unspecified stage		10/17/24		
G82.52	Quadriplegia C1-C4 incomplete		10/17/24		
E11.9	Type 2 diabetes mellitus without complications		10/17/24		
E55.9	Vitamin D deficiency unspecified		10/17/24		
N31.9	Neuromuscular dysfunction of bladder unspecified		10/17/24		
Z43.5	Encounter for attention to cystostomy		10/17/24		
Z43.3	Encounter for attention to colostomy		10/17/24		
Z87.440	Personal history of urinary (tract) infections		10/17/24		
Z79.4	Long term (current) use of insulin		10/17/24		
Z90.49	Acquired absence of other specified parts of digestive tract		10/17/24		
14. DME and Supplies:				15. Safety Measures:	
diabetic supplies, ostomy supplies, urinary/catheter supplies, wheelchair, hospital bed, air mattress				wheelchair precautions, standard precautions, fall precautions, diabetic precautions, smoke detectors , medication safety, infectious material management, aspiration precautions, sharps precautions, cardiac precautions	
16. Nutrition:				17. Allergies:	
diabetic, cardiac diet				no known allergies	
18.A. Functional Limitations				18.B. Activities Permitted	
Endurance, Ambulation				Transfer bed/Chair, Exercises Prescribed, Wheelchair	
19. Mental & Pyschosocial Status: COGNITION: 4. Is totally dependent in toileting., ANXIETY: 0. Never, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:					
20. Prognosis: fair					
22. A Rehabilitation Potential:				22.B.Discharge Plans	
SELF-CARE: , MOBILITY:				family/caregiver will be responsible for managing treatment	
Homebound status: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home					
Clinical Condition Diabetic patient with recent ostomy is quadriplegic and requires skilled nursing for skin checks once a week and suprapubic catheter changes every 4 weeks and Requiring Homecare: prn, SN assessment for cardiopulmonary, neuro, GI/GU, musculoskeletal, and integumentary systems, safety with ADLs and fall precautions, medication and diagnoses management and education.					
SN Careplans				SN Goals	
SN FREQUENCY: SN 1w8 and prn catheter or ostomy complications				PATIENT-STATED GOAL: suprapubic catheter changes, weekly skin checks	
CLINICAL SUMMARY:				GOALS	
Recertification visit completed today. Pt on service for monthly suprapubic catheter changes and weekly skin checks due to history of recurrent pressure ulcers. Pt has colostomy in place which was placed this year. It appears to be functioning well. However pt is reporting occasional bowel movements from rectum. His provider was notified about this. Pt had surgical wound at midline (abdomen). This is is fully healed. Diabetic pt. Blood sugars are usually under 200. He is not 100% compliant with diabetic diet. Pt reports good appetite. Bowel sounds are active x4. Lungs sounds clear. Heart sounds normal. Skin is intact today except for suprapubic site and colostomy site. Nurse provided education regarding colostomy and stoma. Discussed normal appearance of stoma and when to report unusual finding for dark or dry stoma. Cg's assist pt with all ADLs including colostomy appliance changes every 3-4 days. Pt reports peristomal skin is wnl. Pt is quadriplegic with very weak grips. Some edema noted at right ankle. Educated pt on elevating feet and reporting if symptoms remain or worsen. Medications reviewed. Pt educated on high risk medications. Nurse will return next week for skin check and suprapubic catheter change is due by 10/23.				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	
PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 101, heart rate < 50 > 120, respiratory rate < 12 > 29, blood pressure systolic < 85 > 170, blood pressure diastolic < 50 > 90, O2 saturation < 88 > 100, pain < 0 > 8				patient/caregiver recalls * ostomy management including how to clean stoma * change ostomy pouch * recalls related medication(s) purpose, schedule	
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance				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	
23. Signature and Date of Verbal SOC Where Applicable:				25. Date HHA Received Signed POT	
Electronically Signed by JOHNSON, LAURA SN on 10/07/2025					
24. Physician's Name and Address				26. 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. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.	
MICHAEL HUDSON 4212 N 16TH ST PHOENIX, AZ 85016 PHONE: (602) 600-2684 FAX: 16022631665 NPI: 1811006059				F2F date :	
27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face				28. 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.	
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5DG9YC0HT20	10/17/2024	From: 10/12/2025 To: 12/10/2025	1377	037804
6. Patient's Name and Address Curtis Bahe 13820 S 44TH ST APT. 1054, PHOENIX, AZ 85044- 5053399752		7. Provider's Name, Address and Telephone Number Devotion Home Health Care, LLC 11201 N Tatum Blvd, Suite 300 Phoenix, AZ 85028-6039 480-415-4423 1457998957		

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion STANDING ORDERS: Infection control: hygiene, proper hand washing.; Advance directive: plan if patient is unable to make healthcare decisions.no Advanced Directive; Fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn.; Emergency preparedness: plan for prn evacuation, resumption of home health visits. PROBLEMS IDENTIFIED ON ASSESSMENT: dependent edema, abnormal blood pressure, abnormal BS < 70/140 > mg/dL PROCEDURES: ostomy care & irrigation: SN to teach and assist pt/cg with ostomy care as needed, monitor intake & output, catheter change, care & irrigation: Direct Care Nurse to change Foley catheter SILICONE 16 size FR 10 ML/Balloon, to change every 4 wks and PRN for malfunction. OK to flush with sterile saline solution prn if clogged or to maintain patency. TEACH PATIENT/CAREGIVER: * how to optimize mental status with cognition therapy home safety optimize mobility with active and passive range of motion therapeutic exercises diet and fluids to optimize peripheral circulation, 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, * lifestyle modifications low-residue dietary guidelines alternative medicine options for ulcerative colitis, related medication(s) purpose, schedule, * ostomy management including how to clean stoma change ostomy pouch, 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	recalls related medication(s) purpose, schedule patient/caregiver recalls * how to optimize mental status with cognition therapy * home safety * optimize mobility with active and passive range of motion therapeutic exercises * diet and fluids to optimize peripheral circulation * recalls related medication(s) purpose, schedule
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Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by JOHNSON, LAURA SN	10/07/2025