Home Health Certification and Plan of Care

Order ID: 1184/344

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
20251223247949	12/24/2025	From: 12/24/2025 To: 02/21/2026	1405	037804

6. Patient's Name and Address
Kandice Linwright
2080 S Constellation Way,
GILBERT, AZ 85295-
480-254-0145

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

8. DOB 09/09/1980 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S82.142D	Displ bicondylar fx l tibia subs for clos fx w routn heal	12/24/25

13. ICD	Other Pertinent Diagnoses	Date
E87.6	Hypokalemia	12/24/25
E87.20	Acidosis unspecified	12/24/25
F41.9	Anxiety disorder unspecified	12/24/25
F32.A	Depression unspecified	12/24/25
Z79.82	Long term (current) use of aspirin	12/24/25
Z91.81	History of falling	12/24/25

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

Tylenol (Geltab) - Acetaminophen 1000 mg by mouth as necessary acetaminophen 1000 mg by mouth Q8h prn pain (not to exceed 4000mg daily acetaminophen from all sources)
Ibuprofen - Ibuprofen 200 mg 600 mg by mouth as necessary ibuprofen 600 mg by mouth Q8H prn pain
Lorazepam - Lorazepam 0.5 mg BID PRN by mouth as necessary prn anxiety
Methocarbamol - Methocarbamol 750 mg 1 tablet by mouth as necessary TID PRN pain
Oxycodone - Ibuprofen: Oxycodone Hydrochloride 5 mg by mouth every 6 hours prn pain
Hydroxyzine - Hydroxyzine Hydrochloride 25mg by mouth at bedtime
Aspirin 81Mg - Aspirin 81 mg by mouth twice a day to prevent blood clots
Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 mg by mouth after meal BID after meals
Escitalopram - Escitalopram Oxalate 20 mg 1 tablet by mouth once a day DAILY
Senna S - Senna 50-8.6mg capsule by mouth twice a day
Zyrtec - Cetirizine Hydrochloride 1 tablet by mouth once a day

14. DME and Supplies:
commode, bath bench, walker, wheelchair, wound care supplies

15. Safety Measures:
walker precautions, smoke detectors , bathroom safety, medication safety, wheelchair precautions, remove environmental barriers, standard precautions, infectious material management, fall precautions, bleeding precautions, , ambulates with device

16. Nutrition:
high protein

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation

18.B. Activities Permitted
Walker, Wheelchair, Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial Status: 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: Yes

20. Prognosis: fair

22. A 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.

22.B.Discharge Plans
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 Requiring Homecare: Patient with recent fracture/surgery to left lower leg requires SN assessment for cardiopulmonary, neuro, GI/GU, musculoskeletal and integumentary systems, safety with ADLs and fall precautions, medication and diagnoses management and education, wound care and assessment of left lower leg surgical site weeky and as needed for complications.

SN Careplans

SN FREQUENCY: SN 1w8 and prn wound complications or medication changes

CLINICAL SUMMARY:

SOC completed. Pt's wife also present for visit. Pt fell at work on December 8th and fractured left lower leg. She originally went to Banner Baywood but was transferred to Desert Banner. Original hospital discharge was December 11th but pt went back due to pain and had another surgery. External fixation has been removed. Pt has several surgical dressings in place. They were not removed during vist. Nurse did remove ace wrap to observe left leg which has mild edema. There is no redness or other signs of infection visible. Pt will see surgeon on Wednesday and nurse will see pt after that to assist with any wound care ordered. Head to to assessment completed. Other than left leg injury, no unusual findings. Heart sounds normal, lungs clear. Bowel sounds hypoactive. Pt reports had bowel movement today. Nurse provided education on bowel care medication. Pt recently stopped the oxycodone due to unwanted side effects. She will be taking tylenol and ibuprofen for pain management. Pt reports eating well. She has a walker and wheelchair. HH PT has been ordered. Pt requires assistance for most ADLs and wife assists as primary caregiver. Nurse performed home safety assessment, educated on all medications, reviewed fall prevention, pain management and ways to reduce edema. Advised pt and cg when to call 911 or seek emergent medical attention. Nurse will see pt weekly and prn until cg is independent with pt's care.

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

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

SN Goals

PATIENT-STATED GOAL: heal wound without infection; improve strength

GOALS
patient/caregiver recalls
* pain control
* therapeutic exercises to optimize range of motion of affected area
* diet and fluids to promote healing
* 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 m

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) purpos

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by JOHNSON, LAURA SN on 12/24/2025

25. Date HHA Received Signed POT

24. Physician's Name and Address
NILOOFAR DEGHAN
18444 N 25TH AVE STE 210 PHOENIX, AZ
PHOENIX, AZ 85023-1264
PHONE: 866-974-2673 FAX: 866-974-2673 NPI: 1295272334

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.
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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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:

Infection control: hygiene, proper hand washing.;

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.;

Advance directive: plan if patient is unable to make healthcare decisions.MPOA (wife)

PROBLEMS IDENTIFIED ON ASSESSMENT: D0160 - Depression, M1720 - Anxiety, meal preparation, M2020 - Oral Med Management, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, nausea/vomiting, constipation, muscle weakness, limited strength, limited range of motion, limited endurance, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, #1 - Observable Surgical Wound - Anterior Left Below Knee - non-observable incision to left lower leg

PROCEDURES:

physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Left Below Knee - non-observable incision to left lower leg,

home exercise program,

coordinate/arrange preparation of missing meals

TEACH PATIENT/CAREGIVER: * 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 relaxatio, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related m, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * pain control therapeutic exercises to optimize range of motion of affected area diet and fluids to promote healing, 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, meal preparation is available to patient for all meals

including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxatioN

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

meal preparation is available to patient for all meals

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by JOHNSON, LAURA SN	12/24/2025