Home Health Certification and Plan of Care

Order ID: 1184/358

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1TD3JU3VP11	09/09/2025	From: 01/07/2026 To: 03/07/2026	1392	037804

6. Patient's Name and Address
Diana Peters
5474 E. Billings St,
MESA, AZ 85205-
480-450-8270

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 11/06/1949 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
M80.08XD	Age-rel osteopor w crnt path fx verteb 7thD	09/09/25

13. ICD	Other Pertinent Diagnoses	Date
I11.0	Hypertensive heart disease with heart failure	09/09/25
I50.9	Heart failure unspecified	09/09/25
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	09/09/25
G93.40	Encephalopathy unspecified	09/09/25
D02.22	Carcinoma in situ of left bronchus and lung	09/09/25
J44.9	Chronic obstructive pulmonary disease unspecified	09/09/25
D72.10	Eosinophilia unspecified	09/09/25
F32.9	Major depressive disorder single episode unspecified	09/09/25
J33.9	Nasal polyp unspecified	09/09/25
J30.9	Allergic rhinitis unspecified	09/09/25
Z79.01	Long term (current) use of anticoagulants	09/09/25
Z79.82	Long term (current) use of aspirin	09/09/25
Z95.5	Presence of coronary angioplasty implant and graft	09/09/25
Z86.73	Prsnl hx of TIA (TIA) and cereb infrc w/o resid deficits	09/09/25
Z91.81	History of falling	09/09/25

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

fexofenidine 1 tablet, 180 mg by mouth once a day
Escitalopram - Escitalopram Oxalate 10 mg 1 tablet by mouth in the morning
Aspirin - Aspirin 81mg by mouth once a day for blood thinning
Lidocaine Patch - Lidocaine 5% topical patch topical once a day to affected area, leave on for 12 hours then leave off for 12 hours
Acetaminophen - Acetaminophen 325 mg 3 (three), 325mg tablets by mouth as necessary TID PRN pain ; NTE 4000 mg acetaminophen daily from all sources
airborne 1 tablet by mouth once a day
Budesonide - Budesonide 32mcg/spray nasal solution Nasal once a day
Lisinopril - Lisinopril 20 mg 1 tablet by mouth once a day
Alendronate Sodium - Alendronate Sodium eq 70 mg base 1 by mouth once a week Every Saturday
Carvedilol - Carvedilol 3.125 mg 1 by mouth twice a day
Rosuvastatin Calcium - Rosuvastatin Calcium 20 mg 1 by mouth once a day
Spironolactone - Spironolactone 25 mg 1 by mouth once a day
Jardiance - Empagliflozin 10mg by mouth once a day
Ferrous Fumarate - Ferrous Fumarate 300mg by mouth once a day
Furosemide - Furosemide 40 mg 1 by mouth once a day
Isosorbide Mononitrate - Isosorbide Mononitrate 30 mg 1 by mouth in the morning
Spiriva Handihaler - Tiotropium Bromide Monohydrate 18 mcg inhalant once a day
cholecalciferol 25mcg (1000 int units) by mouth once a day

14. DME and Supplies:
bath bench, grab bars, 4 wheeled walker

15. Safety Measures:
fall precautions, ambulates with device, standard precautions, anticoagulant precautions

16. Nutrition:
low sodium,

17. Allergies:
sulfamethoxazole

18.A. Functional Limitations
Ambulation, Endurance

18.B. Activities Permitted
Walker, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: , BEHAVIORAL ISSUES: , HISTORY OF DEPRESSION:

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: , MOBILITY:

22.B.Discharge Plans
patient will be responsible for managing treatment
patient will be responsible for managing treatment

Homebound status: Patient with significant cardiac history, CVA and MI, recent hematochezia, high fall risk and recent vertebral fracture requires use of assistive devices and there is a taxing effort to leave home.

Clinical Condition Requiring Homecare: Patient with significant cardiac history, CVA and MI, recent hematochezia, high fall risk and recent vertebral fracture requires SN for assessment of Cardiopulmonary, GI/GU, Musculoskeletal, Neuro and Integumentary systems, fall prevention and safety with ADLs, diagnoses and medication education/management once weekly and as needed for complications in addition to daily remote BP monitoring.

SN Careplans

SN FREQUENCY: 1W9 and PRN for complications.

CLINICAL SUMMARY: Patient seen today for recertification for HH services. Patient assessed head to toe, skin assessed head to toe and is significant for multiple small bruises on bilateral arms, but otherwise intact and without areas of concern. Vital signs significant for considerable hypotension, lower with automatic BP cuff, higher with manual measurement, but still hypotensive. Patient reports poor appetite and some diarrhea. Patient recently had short stay in hospital due to hematochezia and received 5 units of blood for hemoglobin of 4. Patient and caregiver, daughter, educated on both ways to increase blood pressure and decrease loose stools while boosting potassium levels as well. Patient and daughter voiced understanding of instructions provided. Patient had multiple changes made to medications and these were discussed at length as well. Patient has an appointment with Tri-City Cardiology tomorrow, the 7th to discuss medication changes as well as a potential issue with her mitral valve and possible placement of a watchman device. Caregiver advised to discuss current use of daily Lasix and Spironolactone and changes made to Metoprolol. Patient states she will keep all of her cardiac care only at Tri-City cardiology going forward as having services at both Tri-City and PIMC is too confusing and doctors are managing her differently. Patient also has an appointment next week, January 14th at PIMC for primary care follow-up and will be scheduling lab work and a colonoscopy. Medications reconciled with patient and caregiver, plan of care discussed for new episode and all questions answered. Patient to continue to be seen by SN weekly and as needed for complications for assessment, diagnoses and medication management.

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 101, heart rate < 50 > 120,

SN Goals

PATIENT-STATED GOAL: safety in home, no falls

GOALS
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 manage complications of immobility including
* skin care
* strength, balance
* dexterity and range-of-motion therapeutic exercises
* promotion of peripheral circulation
* fluid and diet intake to promote healing and prevent constipation

patient/caregiver recalls
* strategies to increase caloric intake
* recalls related medication(s) purpose, schedule

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by JOHNSON, LAURA SN on 01/06/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
MARIA BELLANTONI
4212 N 16TH ST
PHOENIX, AZ 85016
PHONE: (602) 263-1200 FAX: 16022631665 NPI: 1689162307

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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respiratory rate < 12 > 29, blood pressure systolic < 85 > 170, blood pressure diastolic < 50 > 90, O2 saturation < 88 > 100, pain < 0 > 8

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, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 7. Currently taking 5 or more medications

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.

Advance Directive: No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: swelling in legs/around eyes, diarrhea, tarry/bloody stools, loss of appetite

PROCEDURES: Nurse to fill medi-set: SN to reconcile medi-set with patient weekly

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.

* strict compliance with physician orders for anticoagulant administration avoiding activities that create unnecessary risk for injury monitoring for prolonged bleeding from cuts, blood in urine or stool, or unusual bruising for warfarin, limiting foods high in Vitamin K, such as leafy green vegetables.

* lifestyle modification to manage blood condition including dietary changes bleeding precautions, 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 to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule.

* 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.

* 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 manage complications of immobility including skin care strength, balance dexterity and range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing and prevent constipation.

* strategies to increase caloric intake, 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.

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

patient/caregiver recalls
* lifestyle modification to manage blood condition including dietary changes
* bleeding precautions
* 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

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

patient/caregiver recalls
* strict compliance with physician orders for anticoagulant administration
* avoiding activities that create unnecessary risk for injury
* monitoring for prolonged bleeding from cuts, blood in urine or stool, or unusual bruising
* for warfarin, limiting foods high in Vitamin K, such as leafy green vegetables

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by JOHNSON, LAURA SN

Date
01/06/2026