Home Health Certification and Plan of Care

Order ID: 1184/460

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
104523838	03/06/2026	From: 03/06/2026 To: 05/04/2026	1414	037804

6. Patient's Name and Address

Charmelle Butler
5832 S 26TH PLACE,
PHOENIX, AZ 85040-
(602) 741-4408

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 01/14/1974 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
N39.0	Urinary tract infection site not specified	03/06/26

13. ICD	Other Pertinent Diagnoses	Date
F88.	Other disorders of psychological development	03/06/26
G40.909	Epilepsy unsp not intractable without status epilepticus	03/06/26
I10.	Essential (primary) hypertension	03/06/26
E11.9	Type 2 diabetes mellitus without complications	03/06/26
F31.9	Bipolar disorder unspecified	03/06/26
I89.0	Lymphedema not elsewhere classified	03/06/26
G47.419	Narcolepsy without cataplexy	03/06/26
D25.9	Leiomyoma of uterus unspecified	03/06/26
D64.9	Anemia unspecified	03/06/26
F41.9	Anxiety disorder unspecified	03/06/26
G47.30	Sleep apnea unspecified	03/06/26
K21.9	Gastro-esophageal reflux disease without esophagitis	03/06/26
R45.851	Suicidal ideations	03/06/26
Z79.899	Other long term (current) drug therapy	03/06/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	03/06/26
Z79.82	Long term (current) use of aspirin	03/06/26
Z90.49	Acquired absence of other specified parts of digestive tract	03/06/26

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

CEFDINIR 300 mg, 1 cap Oral BID, for 7 days for UTI
Asa 81 Mg - Aspirin 81 mg by mouth once a day for blood thinning
BENZTROPINE 1 mg Oral BID
BUSPAR 10 mg Oral BID
CETIRIZINE HYDROCHLORIDE 10 mg Oral Daily
CHLORPROMAZINE HYDROCHLORIDE 100 mg Oral TID to treat behavioral symptoms
DEPAKOTE 1,000 mg Oral QMorning, @7am
Depakote - Divalproex Sodium 1500 mg by mouth once a day @ 7PM
FUROSEMIDE 40 mg Oral Daily
GABAPENTIN 600 mg Oral TID
LISINIPRIL 40 mg Oral Daily
Metformin - Metformin Hydrochloride 1000 mg by mouth twice a day for diabetes
SERTRALINE 200 mg Oral at bedtime
semaglutide 3 mg= 1 tab Oral Daily Rybelsus 3 mg oral tablet for diabetes
QUETIAPINE FUMARATE 600 mg Oral at bedtime for behavioral symptoms
Metoprolol Tartrate - Metoprolol Tartrate 25 mg 1 tablet by mouth twice a day
Potassium Chloride - Potassium Chloride 4meq/ml 2 tablets by mouth once a day

supplemental oxygen- 4L/min continuous via nasal cannula

14. DME and Supplies:

walker, hospital bed, grab bars, wheelchair, Hospital bed

15. Safety Measures:

supervision at all times, remove environmental barriers, diabetic precautions, fall precautions, medication safety, smoke detectors , walker precautions, wheelchair precautions, standard precautions, ambulates with device

16. Nutrition:

diabetic

17. Allergies:

penicillin (Moderate), TEGretol XR (Mild), carbAMAZepine (Unknown), levothyro:

18.A. Functional Limitations

Ambulation, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted

Walker, Wheelchair, Exercises Prescribed, Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 3. During the day and evening, but not constantly, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!4. Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)!5. Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions), HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans

family/caregiver will be responsible for managing treatment
add discharge plan

Homebound status: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home, medical condition could get worse if patient leaves home

Clinical Condition Requiring Homecare: Diabetic pt recently hospitalized and diagnosed with UTI requires SN assessment for cardiopulmonary, neuro, GI/GU, musculoskeletal and integumentary systems, safety with ADLs and fall precautions, medication and diagnoses management and education once a week and as needed for complications.

SN Careplans

SN FREQUENCY: 1w1 and prn for medication changes

CLINICAL SUMMARY:

SN visit for home health SOC visit. Pt was referred to home health for PT/OT. No OT currently available. HH PT will see pt. Pt lives in a behavioral health group home. She was recently hospitalized for behavioral symptoms at Banner Estrella. She was diagnosed with a UTI. Pt denies current symptoms. She is currently taking antibiotics. Nurse reviewed medication list from the referral but group home staff was unable to provide nurse with a list to confirm. Reviewed medications and safety concerns. Nurse performed head to toe assessment on pt. She is on continuous oxygen at 4L/min via nasal cannula. Lungs sounds diminished on right side but clear otherwise. C/O shortness of breath with moderate exertion. Heart sounds normal and bowel sounds active x4 quadrants. Pt is diabetic but she does not have blood sugar checked routinely. Denies symptoms of high or low blood sugar. She needs assistance with all ADLs including assistance with all meal preparation. Dependent on assistive device to ambulate. Pt has walker and wheelchair available. Pt reports occasional constipation but states she is able to control her bowel and bladder

SN Goals

PATIENT-STATED GOAL: safety in home, no falls

GOALS
patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by JOHNSON, LAURA SN on 03/06/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Sohail Alam
9201 W THOMAS RD
PHOENIX, AZ 85037-3332
PHONE: 623-327-7313 FAX: 623-327-5437 NPI: 1598758450

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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available. Pt reports occasional constipation but states she is able to control her bowel and bladder. Lymphedema present bilateral legs. Nurse provided education on ways to reduce edema. Pt because agitated during visit and grabbed nurses tablet. She did not allow nurse to perform full skin assessment. Group home staff report that they look at her skin during shower time and that skin is intact. Nurse explained signs of skin breakdown and ways to avoid it. Safety assessment performed and fall precautions reviewed. Nurse will return for one additional visit if requested. Otherwise, HH PT will see pt for evaluation with treatment.

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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 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 (brother)

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, M1745 - Behavioral Issues, M1700 - Cognition, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M2020 - Oral Med Management, M1400 - Dyspnea, dependent edema, M1033 - Exhaustion, constipation, M1600 - UTI, muscle weakness, limited endurance, limited strength, balance deficit, Pain Interference with ADLs, Pain Effect on Sleep, obesity

PROCEDURES:

train caregiver(s) to perform medical/rehabilitation treatments,

coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion,

teach/coordinate/arrange medication packaging and/or administration,

coordinate/arrange for adequate patient supervision

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 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, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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 is adequately supervised, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

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
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by JOHNSON, LAURA SN	03/06/2026