Home Health Certification and Plan of Care

Order ID: 1184/475

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
A24450555	03/20/2026	From: 03/20/2026 To: 05/18/2026	1423	037804

6. Patient's Name and Address

Andrea Kalectaca
5132 N 15TH ST APT 158,
PHOENIX, AZ 85014-
928-240-3959

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 12/24/1962 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
L97.913	Non-prs chronic ulc unsp prt of r low leg w necros muscle	03/20/26

13. ICD	Other Pertinent Diagnoses	Date
L88.	Pyoderma gangrenosum	03/20/26
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	03/20/26
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	03/20/26
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	03/20/26
N18.30	Chronic kidney disease stage 3 unspecified	03/20/26
E78.5	Hyperlipidemia unspecified	03/20/26
Z79.01	Long term (current) use of anticoagulants	03/20/26
Z86.711	Personal history of pulmonary embolism	03/20/26
Z86.718	Personal history of other venous thrombosis and embolism	03/20/26

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

Omeprazole - Omeprazole 20 mg 20 mg by mouth twice a day Give 1 capsule by mouth two times a day for GERD
Vitamin B Complex - Alpha-Tocopherol Acetate: Ascorbic Acid: Biotin: Cholecalciferol: Cyanocobalamin: Dexpanthenol: Folic Acid: Niacinamide: Pyridox 0 1 tablet by mouth once a day Give 1 tablet by mouth one time a day for supplement
Apixaban 0 5 mg by mouth twice a day for DVT PPX
Amlodipine Besylate - Amlodipine Besylate eq 10 mg base eq 10 mg base 1 tablet by mouth once a day For HTN
LISINIPRIL 0 40 MG Oral Give one time a day for HTN
Empagliflozin 0 10 mg by mouth once a day for diabetes
Tramadol Hcl - Tramadol Hydrochloride 0 100 MG by mouth as necessary every 6 hours PRN pain
GABAPENTIN 300 mg 300 mg 100 MG Oral every 8 hours
HYDROcodone-Acetaminophen 0 325 mg by mouth as necessary Give 1 tablet by mouth every 12 hours as needed for wound care break through pain
ozempic 1mg subcutaneous once a week for diabetes

14. DME and Supplies:

diabetic supplies, walker, wheelchair, wound care supplies, 4 wheeled walker, bath bench

15. Safety Measures:

walker precautions, smoke detectors , medication safety, infectious material management, fall precautions, diabetic precautions, sharps precautions, wheelchair precautions, standard precautions, cardiac precautions, bleeding precautions, anticoagulant precautions, ambulates with device

16. Nutrition:

high protein, diabetic, cardiac diet

17. Allergies:

Ibuprofen, oxyCODONE, Pioglitazone, Benadryl, Motrin, latex

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker, Wheelchair, 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: No

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

patient will be responsible for managing treatment

Homebound status: Homebound due to generalized weakness, large wound on right leg and dependence on assistive device to ambulate

Clinical Condition Requiring Homecare: Non-Pressure Chronic Ulcer of Unspecified part of Right lower leg with Necrosis of muscle; Diabetic patient with large wound at right 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 per orders 3 times per week and as needed for complications 3/20/26-3/31/26 Diabetic patient with large wound at right 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 per orders 3 times per week and as needed for complications 4/01/26-4/30/26 Diabetic patient with large wound at right 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 per orders 3 times per week and as needed for complications 5/01/26-5/18/26

SN Careplans

SN FREQUENCY: SN 1w1, 3w7 and prn for wound complications

CLINICAL SUMMARY:

SOC visit completed with pt. Pt lives alone in an apartment. She has family and friends nearby who assist her occasionally. A&O x4. She is mostly independent with ADLs. Pt was discharged home Tuesday from a SNF. Right lower leg with large wound which started from a scratch. The wound became infected and pt was hopsitalized in December. She reportedly had 8 surgeries. The wound is now very painful, large and is approximately 9 x14 x 0.3cm. Most of the wound bed is beefy red, granulation tissue. However there is a small amount of slough and escar tissue present. No other signs of infection. Wound care is santyl to wound bed followed by vashe wet to dry. Pt has severe pain with dressing changes. Lidocaine has been ordered but none is available today. Nurse will assist pt in obtaining lidocaine for future wound care visits. Pt is diabetic. Nurse performed head to toe assessment. Skin intact except wound being treated at lower right leg. Lungs sounds clear throughout. Heart sounds normal. Bowel sounds active x4 quadrants. Pt reports good appetite. She ambulates with walker or wheelchair. Nurse performed wound care today per orders. Pt had pain with dressing change but pain returned to baseline level after care was performed. Home safety assessment complete. Pt educated on fall precautions. Nurse reviewed all medications with pt. Nurse will see pt Mondays, Wednesdays and Fridays and she will go to wound clinic on Thursdays.

SN Goals

PATIENT-STATED GOAL: heal wound; decreased pain

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 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
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by JOHNSON, LAURA SN on 03/20/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

HELEN HAYDEN
4212 N 16th St
Phoenix, AZ 85016
PHONE: 602-263-1200 FAX: 16022005387 NPI: 1700161791

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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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, blood sugar < 60 > 300

CAREGIVER: 3. Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

HOSPITALIZATION RISKS: 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:

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. No Advanced Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, M2020 - Oral Med Management, A1250 - Lack of Necessary Transportation, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, M1400 - Dyspnea, abnormal blood pressure, abnormal BS < 70/140 > mg/dL, constipation, limited endurance, muscle weakness, limited strength, extremity burn/tingle/numb, balance deficit, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, #1 - Observable Surgical Wound - Anterior Right Below Knee -

PROCEDURES:

physician-ordered wound care: #1 - Observable Surgical Wound - Anterior Right Below Knee -: Right lower leg wound care: remove old dressing; apply lidocaine gel for 10 minutes; cleanse wound with vashe wound cleanser, pat dry with 4x4 gauze, apply santyl to wound bed, cover wound with vashe soaked 4x4 gauze, dry 4x4 gauze and abd pad, wrap with kerlix and ace wrap frequency: daily and prn for soiling or dislodgement; SN visits 3 times per week,

apply compression bandage,

glucose testing via monitor,

monitor intake & output,

teach/coordinate/arrange medication packaging and/or administration

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, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * 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's transportation needs are met, patient is adequately supervised

record wound measurements
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase caloric intake
* 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

patient's transportation needs are met

patient is adequately supervised

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by JOHNSON, LAURA SN	03/20/2026