Home Health Certification and Plan of Care

Order ID: 1184/510

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
104530314	04/15/2026	From: 04/15/2026 To: 06/13/2026	1426	037804

6. Patient's Name and Address

Darby Wood
4833 E MARCONI AVE,
SCOTTSDALE, AZ 85254-1634
602-795-6107

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 11/24/1960 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
L89.150	Pressure ulcer of sacral region unstageable	04/15/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	04/15/26
E11.9	Type 2 diabetes mellitus without complications	04/15/26
J44.9	Chronic obstructive pulmonary disease unspecified	04/15/26
G47.33	Obstructive sleep apnea (adult) (pediatric)	04/15/26
F25.1	Schizoaffective disorder depressive type	04/15/26
L60.3	Nail dystrophy	04/15/26
Z79.84	Long term (current) use of oral hypoglycemic drugs	04/15/26
Z79.82	Long term (current) use of aspirin	04/15/26

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

METFORMIN tablet (500 mg) Oral bid with a meal for diabetes
ERGOCALCIFEROL MG Oral once a day vitamin D
Tradjenta - Linagliptin 5mg tablets by mouth once a day for diabetes
CLOZAPINE 100 mg tablet Oral daily
Sertraline - Sertraline Hydrochloride 100mg tablet by mouth once a day
PANTOPRAZOLE 40 mg MG Oral once a day
Ferosul - Ferrous Sulfate: Folic Acid 325mg (65 Fe) by mouth once a day
Ondansetron - Ondansetron 8 mg 1 tablet by mouth as necessary every 8 hrs prn for nausea
FOLIC ACID 1 mg TABLET by mouth ONCE DAILY
LIOTHYRONINE SODIUM 5 MCG Oral once a day
LEVOTHYROXINE 200 MCG Oral once a day
GABAPENTIN 100 mg MG Oral once a day
DIVALPROEX 500 mg MG Oral once a day for mood
ATORVASTATIN MG Oral once a day
POLYETHYLENE GLYCOL GM Oral as necessary daily PRN for constipation
Budesonide-Formoterol Fumarate 80-4.5 MCG/ACT Aerosol 2 puff Inhalation 2 times per day
Albuterol Sulfate And Ipratropium Bromide - Albuterol Sulfate: Ipratropium Bromide 0.5-2/5 (3) mg/3ML inhalant as necessary every 12H PRN SOB/wheezing
Budesonide - Budesonide 0.5 mg/2ml 1 puff inhalant as necessary daily prn for SOB/wheezing
MUPIROCIN 2 perc 1 application External as necessary to affected area PRN daily to prevent infection
KETOCONAZOLE 2 perc 1 application External two times per week topical (shampoo) as needed to treat irritation
ASPIRIN MG Oral twice a day to prevent clots
Clotrimazole - Clotrimazole 1 perc 1 application topical as necessary PRN daily for fungal infection
ALBUTEROL 108 MCG/ACT Inhalation as necessary 1 puff every 4 hours prn SOB/wheezing
Medihoney 1 application topical threee times per week 3 times per week and PRN - apply to wound bed during wound care
Oxygen - Oxygen 2.5L/min nasal cannula continuous

14. DME and Supplies:

diabetic supplies, hoyer lift, hospital bed, wound care supplies, oxygen supplies

15. Safety Measures:

bleeding precautions, diabetic precautions, fall precautions, sharps precautions, standard precautions, infectious material management, smoke detectors , O2 precautions, medication safety, cardiac precautions, anticoagulant precautions

16. Nutrition:

cardiac diet, diabetic, high protein

17. Allergies:

no known allergies

18.A. Functional Limitations

Endurance, Ambulation, Bowel/Bladder Incontinence, Hearing, Amputation

18.B. Activities Permitted

Bedbound

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, 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, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:

SELF-CARE: 1. Dependent - A helper completed all the activities for the patient., MOBILITY: 1. Dependent - A helper completed all the activities for the patient.

22.B.Discharge Plans

another facility/provider 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, medical condition could get worse if patient leaves home

Clinical Condition Requiring Homecare: Diabetic pt with large Unstageable wound at her sacrum requires SN assessment for cardiopulmonary, neuro, GI/GU, musculoskeletal, and integumentary systems, safety with ADLs and fall precautions, medication and diagnoses management and education and wound care 3 times per week and prn for complications. <span style="font-size: 10.5pt; font-family: Arial, sans-serif; font-variant-numeric: normal; font-variant-east-asian: normal; font-variant-alternates: normal; font-variant-position: normal; vertical-align: baseline; white-space-collapse: preserve;">

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by JOHNSON, LAURA SN on 04/15/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

JOEL COHEN
7010 E ACOMA DR SUITE 102
SCOTTSDALE, AZ 85254-3553
PHONE: 480-575-0576 FAX: 14805750512 NPI: 1700934684

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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SN FREQUENCY: SN 2w1,3w7 and prn for wound complications

CLINICAL SUMMARY:

SOC visit completed. Pt lives in group home. A&O x3-4 with some forgetfulness. History of schizophrenia reported. Medical history includes COPD, htn, OSA and DM. She is bedbound and dependent on caregivers for assistance with all of her ADLs. She can feed herself with meal set-up. Pt is oxygen dependent and o2 is set at 2.5 L/min via nasal cannula. She uses a bi-pap at night. Recent hospitalization includes a 21 day stay in March. Pt was diagnosed with pneumonia and had a UTI. Pt has a large unstagable wound at her sacrum. The periwound has significant redness and the middle of the wound is covered in eschar tissue. Pt c/o pain and is requesting pain medication including a topical pain to be using during wound care. Head to toe assessment completed. Pt unable to turn and reposition on her own. Group home staff assisted nurse in turning pt. Pt appears to have an infection in her left eye which may require antibiotics. She has redness on her nose which she stated is from the bi-pap mask. Nurse provided education to pt and cg regarding preventing pressure ulcer which will form due to medical devices as well. Instructed cg to turn and reposition pt every 2 hours. Pt skin is intact other than the areas mentioned. She has amputations of the left 2nd and 3rd toe. Vitals were wnl. Pt reports fair appetite and regular bowel movements with occasional diarrhea and constipation. Nurse reviewed all medications. Pt is not knowledgeable about her medications and she relies on staff to administer her medication. Nurse called to discuss wound care with following provider. Wound care supplies will be ordered. Today, nurse cleansed the wound and covered it with foam bordered sacral pad. Advised cg to keep the wound clean and replace the dressing as needed. Home safety assessment completed and fall precautions reviewed. Nurse will see pt 3 times per week for wound 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: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12

PATIENT-STATED GOAL: Heal wound, reduce 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
* 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/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient's transportation needs are met

patient is adequately supervised

meal preparation is available to patient for all meals

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	04/15/2026

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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: M1745 - Behavioral Issues, D0700 - Social Isolation, meal preparation, A1250 - Lack of Necessary Transportation, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2020 - Oral Med Management, coughing, abnormal blood pressure, M1400 - Dyspnea, M1033 - Exhaustion, abnormal BS < 70/140 > mg/dL, M1620 - Bowel Incontinence, constipation, diarrhea, M1610 - Urinary Incontinence, muscle weakness, limited strength, limited range of motion, limited endurance, B1000 - Vision Deficit, balance deficit, extremity burn/tingle/numb, Pain Interference with ADLs, obesity, #1 - 5 - Unstageable due to non-removable dressing, slough or eschar. - Other - Sacrum - Unstagable sacral wound

PROCEDURES:

physician-ordered wound care: #1 - 5 - Unstageable due to non-removable dressing, slough or eschar. - Other - Sacrum - Unstagable sacral wound,

cough/deep breathing exercises,

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

physician-ordered wound care: Unstageable sacral wound: Wound care 3 times per week and prn for dislodgement or soiling: cleanse area with wound cleanser, pat dry with 4x4 gauze, apply medihoney to wound bed, cover with LARGE silicone foam sacral dressing.,

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 minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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