Home Health Certification and Plan of Care

Order ID: 1184/629

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
3Q17Y90JY79	07/07/2026	From: 07/07/2026 To: 09/04/2026	1373	037804

6. Patient's Name and Address

Rosie Teller
1055 W Baseline Rd Apt 1089,
MESA, AZ 85210-
602-738-4889

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 12/04/1954 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
A04.72	Enterocolitis d/t Clostridium difficile not spcf as recur (A04.72)	07/07/26

13. ICD	Other Pertinent Diagnoses	Date
L24.A2	Irritant cntct derm d/t fecal urinry or dual incontinence	07/07/26
S80.212D	Abrasion left knee subsequent encounter	07/07/26
E78.5	Hyperlipidemia unspecified	07/07/26
G40.909	Epilepsy unsp not intractable without status epilepticus	07/07/26
I69.398	Other sequelae of cerebral infarction	07/07/26
R29.898	Oth symptoms and signs involving the musculoskeletal system	07/07/26
M06.9	Rheumatoid arthritis unspecified	07/07/26
D64.9	Anemia unspecified	07/07/26
E87.6	Hypokalemia	07/07/26
E83.51	Hypocalcemia	07/07/26
R32.	Unspecified urinary incontinence	07/07/26
Z79.82	Long term (current) use of aspirin	07/07/26
Z87.440	Personal history of urinary (tract) infections	07/07/26

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

Phenytoin - Phenytoin 100 mg capsules by mouth at bedtime phenytoin 100mg capsules - take 3 capsule by mouth at bedtime to prevent seizures
Acetaminophen - Acetaminophen 650 mg 1 by mouth as necessary Give 1 tablet by mouth every 4 hours as needed for pain; nte 3gm/24 hrs; do not crush
Vancocin Hydrochloride - Vancomycin Hydrochloride eq 125 mg base 1 by mouth twice a day
Kcl - Potassium Chloride 10 mEq by mouth once a day

14. DME and Supplies:

bath bench, urinary/catheter supplies, wheelchair, walker, grab bars, wound care supplies, 4 wheeled walker

15. Safety Measures:

fall precautions, transfer with assist, standard precautions, seizure precautions, activity supervision

16. Nutrition:

high calorie, high protein

17. Allergies:

antibiotics!pcn

18.A. Functional Limitations

Endurance, Bowel/Bladder Incontinence, Ambulation!Hearing

18.B. Activities Permitted

Up As Tolerated, Wheelchair

19. Mental & Pyschosocial Status: COGNITION: 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium., ANXIETY: 4. Constantly, SOCIAL ISOLATION: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

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

Homebound status: Taxing effort to leave home, dependence on assistive devices

Clinical Condition Requiring Homecare: Patient with prior medical history of seizure disorder, hyperlipidemia, rheumatoid arthritis and previous falls and recent history of C-diff, vertebral fractures, multiple falls, pericarditis and UTI requires SN assessment of cardiopulmonary, neuro, musculoskeletal, GI/GU and integumentary systems, fall precautions and safety with ADLs, medication reconciliation and management, diagnoses management and wound/skin care weekly and as needed for complications.

SN Careplans

SN FREQUENCY: 1W9 and PRN for complications

CLINICAL SUMMARY: Patient assessed for start of care following multiple hospitalizations. Patient referred for home health care for nursing and physical therapy. Patient has a history of epilepsy and rheumatoid arthritis and recently multiple admissions to hospitals and long term care facilities since January after original hospitalization for a vertebral fractures and subsequent C-diff infection that led to sepsis and prolonged ICU stay. Patient has been having issues with significant nausea and keeping down the oral antibiotics given to her to treat the chronic C-diff and has lost over 30 lbs over the last few months according to caregiver (daughter) and is unable to walk independently due to loss of endurance and strength. Patient has developed significant skin breakdown to peri-area from frequent diarrhea and due to being left in wet and soiled briefs while in facilities, per caregiver. Peri-area assessed and photographed for EHR and is being treated with barrier cream, baby powder (or corn starch) and frequent brief changes daily. Patient has skin with a yellowish hue and pallor. Patient complains of abdominal pain and headache currently. Caregiver reports that patient's PO intake is poor and she is "trying to push her to eat and drink all the time, but she doesn't take much." Caregiver provided with education on skin care for peri-area, interventions for increasing calories, and plan of care for PT evaluation and nursing care. Caregiver voiced understanding of instructions and is in agreement with plan. Patient to be seen by SN weekly and as needed for complications for assessment, diagnoses management and wound/skin care. Patient to be evaluated by physical therapy in upcoming week. Evaluation is delayed slightly due to caregiver request for a female therapist.

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,

SN Goals

PATIENT-STATED GOAL: Get stronger, feel better

GOALS
patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin 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/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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by DELGADO, MELISSA SN on 07/07/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Aneesh Sinha

, 0
PHONE: 602-445-0751 FAX: NPI: 1104209402

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 : 07/01/2026

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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O2 saturation < 88 > 100, pain < 0 > 8

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), 2. Unintentional weight loss of a total of 10 pounds or more 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, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 8. Currently reports exhaustion

STANDING ORDERS: Infection control: hygiene, proper hand washing.; Advance directive: plan if patient is unable to make healthcare decisions.; 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: D0160 - Depression, M2020 - Oral Med Management, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, M1400 - Dyspnea, dependent edema, weak pulses in feet, delayed capillary refill, swelling in the arms/legs, M1620 - Bowel Incontinence, nausea/vomiting, abdominal pain, diarrhea, M1610 - Urinary Incontinence, decreased urine output, muscle weakness, limited strength, limited endurance, lethargy, B1000 - Vision Deficit, Pain Effect on Sleep, Pain Interference with ADLs, headache, weak hand grips, seizures, daytime fatigue, balance deficit, loss of appetite, pallor, red/tender pressure points, skin breakdown r/t incontinence

PROCEDURES: physician-ordered wound care: gently cleanse area, apply barrier cream to affected area, add corn starch or baby powder if desired, apply daily and as needed. Do not scrub barrier cream off.

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 relaxation skills and diversional activities, 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, * strategies to increase caloric intake, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids

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

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* 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

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by DELGADO, MELISSA SN	07/07/2026