Home Health Certification and Plan of Care

Order ID: 1184/636

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

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

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

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: other

Clinical Condition Requiring Homecare: PLACEHOLDER

SN Careplans

SN WK1: 1 (07/02/26-07/04/26)

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: 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

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
* strategies to increase caloric intake

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
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 : 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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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

* 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