

Home Health Certification and Plan of Care				Order ID: 1184/570	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
48238250		05/13/2026		From: 05/13/2026 To: 07/11/2026	
				4. Medical Record No.	
				1430	
				5. Provider No.	
				037804	
6. Patient's Name and Address Antoinette Alderette 1518 Fremont Dr, TEMPE, AZ 85282- 956-205-5090				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 10/06/1979 9.Sex Female				10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
11. ICD		Principal Diagnosis		Date	
Z48.3		Aftercare following surgery for neoplasm		05/13/26	
13. ICD		Other Pertinent Diagnoses		Date	
C20.		Malignant neoplasm of rectum		05/13/26	
D63.0		Anemia in neoplastic disease		05/13/26	
N82.3		Fistula of vagina to large intestine		05/13/26	
D25.9		Leiomyoma of uterus unspecified		05/13/26	
E04.1		Nontoxic single thyroid nodule		05/13/26	
Z43.3		Encounter for attention to colostomy		05/13/26	
Z90.49		Acquired absence of other specified parts of digestive tract		05/13/26	
14. DME and Supplies: bath bench, ostomy supplies				15. Safety Measures: fall precautions, bleeding precautions, remove environmental barriers, , , standard precautions, infectious material management, smoke detectors , medication safety, bathroom safety, anticoagulant precautions	
16. Nutrition: high protein, soft, low fiber				17. Allergies: no known allergies	
18.A. Functional Limitations Endurance, , Ambulation				18.B. Activities Permitted Up As Tolerated	
19. Mental & COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Pyschosocial Status: 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: Patient homebound due to generalized weakness and recent surgeries					
Clinical Condition Patient with recent history of multiple surgeries, jp drain and colostomy in place requires SN assessment for Requiring Homecare:cardiopulmonary, neuro, GI/GU, musculoskeletal and integumentary systems, safety with ADLs and fall precautions, medication and diagnoses management and education, weekly and as needed for complications. 					
SN Careplans SN FREQUENCY: SN 1w8 and prn for wound, JP drain or ostomy complications CLINICAL SUMMARY: Nurse met with patient at her home for home health start of care visit. Patient recently discharged from the hospital. She was hospitalized on April 30 and discharged yesterday. During her hospital stay she had a hysterectomy, fistula repair and removal of her rectum. Patient had a colonostomy placed in October. She currently has a large midline surgical wound which has a non-removable surgical dressing in place. Nurse confirm with the doctor that that dressing should stay in place until she sees them again. JP drain located at right lower abdomen. Nurse provided education to pt on how to milk the tubing, measure the output and create vacuum in bulb. Patient reports and output of 10 cc this morning. Colonostomy is located at the left lower abdomen. Discussed proper diet and appropriate output. Patient has a right upper chest port which is not accessed currently. Several bruises on her arms from IVs, which were in place while hospitalized. Nurse performed head to toe assessment of patient. Skin intact except surgical sites mentioned previously. Heart sounds normal, lungs clear, bowel sound hyperactive. Patient reports a poor appetite, but she is eating. Nurse encouraged patient to increase protein in her diet to promote wound healing. She has generalized weakness and requires some assistance with ADLs. However, she is not using an assistive device to ambulate at this time. Home health physical therapy has been ordered. Nurse reviewed all medications with patient advised patient of her increased risk of bleeding. Discussed signs of bleeding and what to look for and what to do in case of bleeding. Patient reports peristomal skin is within normal limits. She is knowledgeable about how to change the ostomy appliance she receives assistance from her mother. Denies pain at this time. Provided education on fall prevention and performed home safety assessment. Nurse will see patient once a week through certification period. 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				SN Goals PATIENT-STATED GOAL: Safety in home GOALS patient/caregiver recalls * ostomy management including how to clean stoma * change ostomy pouch * 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 increase caloric intake * recalls related medication(s) purpose, schedule patient/caregiver recalls * ostomy management including how to clean stoma * change drainage pouch * diet restrictions * 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	
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by JOHNSON, LAURA SN on 05/13/2026				25. Date HHA Received Signed POT	
24. Physician's Name and Address ANDREW SALEEB 13400 E SHEA BLVD SCOTTSDALE, AZ 85259-5452 PHONE: 480-342-2697 FAX: 14803421772 NPI: 1790579852				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 : 05/12/2026	
27. Attending Physician's Signature and Date Signed 05/19/2026 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. PAGE 1 of 3	

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HOSPITALIZATION RISKS: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 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: M2020 - Oral Med Management, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, meal preparation, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, M1400 - Dyspnea, lightheadedness, limited endurance, limited strength, muscle weakness, balance deficit, headache, loss of appetite, M1630 - GI Ostomy, #1 - Non-Observable Surgical Wound - Anterior Midline - Non-removable surgical dressing in place, #2 - Other - Anterior Right Abdomen - JP drain, #3 - GU Ostomy - Anterior Left Abdomen - Colostomy PROCEDURES: physician-ordered wound care: #3 - GU Ostomy - Anterior Left Abdomen - Colostomy: Monitor for complications, physician-ordered wound care: #2 - Other - Anterior Right Abdomen - JP drain: Monitor for complications, physician-ordered wound care: #1 - Non-Observable Surgical Wound - Anterior Midline - Non-removable surgical dressing in place: Monitor for complications, ostomy care & irrigation, coordinate/arrange for adequate patient supervision TEACH PATIENT/CAREGIVER: * 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, * ostomy management including how to clean stoma change drainage pouch diet restrictions, related medication(s) purpose, schedule, * ostomy management including how to clean stoma change ostomy pouch, 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 is adequately supervised		patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule patient is adequately supervised		
PT Careplans		PT Goals		
PT		PATIENT-STATED GOAL: add patient-stated goal		
PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, Pain Interference with ADLs, Pain Interference with Therapy activities, Pain Effect on Sleep, GG0170P1 - Picking Up Object, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130B1 - Oral Hygiene, GG0130A1 - Eating, GG0170F1 - Toilet Transfer, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170E1 - Chair to Bed to Chair, GG0170D1 - Sit to Stand		GOALS Chair to Bed to Chair - 06. Independent		
PROCEDURES: cough/deep breathing exercises, incentive spirometer, home exercise program, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training		Toilet Transfer - 06. Independent		
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, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Picking Up Object - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent		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		
		Sit to Stand - 06. Independent		
		Car Transfer - 06. Independent		
		Walk 10 Feet - 06. Independent		
		Walk 50 ft with 2 Turns - 06. Independent		
		Walk 150 Feet - 06. Independent		
		Walk 10 ft on Uneven Surface - 06. Independent		
Signature of Physician:		Date		
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Optional Name/Signature of Nurse/Therapist:		Date		
Electronically Signed by JOHNSON, LAURA SN		05/13/2026		

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		Walk To Room Shower Surface - 06. Independent 1 - Step (curb) - 06. Independent 4 Steps - 06. Independent 12 Steps - 06. Independent Picking Up Object - 06. Independent Oral Hygiene - 06. Independent Toileting Hygiene - 06. Independent Shower/Bathe Self - 06. Independent Lower Body Dressing - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent Upper Body Dressing - 06. Independent		

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