# 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 | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 48238250 | 05/13/2026 | From: 05/13/2026 To: 07/11/2026 | 1430 | 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**

Acetaminophen - Acetaminophen 500 mg tablets by mouth as necessary 2 tablets by mouth every 6 hr prn for pain
Cefadroxil - Cefadroxil/Cefadroxil Hemihydrate eq 500 mg base 1 capsule by mouth twice a day For infection
Eliquis - Apixaban 2.5mg tablets by mouth twice a day For blood thinning (prevent clots)
Methocarbamol - Methocarbamol 500 mg 2 tablets by mouth as necessary 2 tablets 3 times a day as needed for muscle spasms

| 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 & 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:** Patient homebound due to generalized weakness and recent surgeries

**Clinical Condition Requiring Homecare:** Patient with recent history of multiple surgeries, jp drain and colostomy in place requires SN assessment for 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.<br>

## 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: 14803423467 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** **07/30/2026**: 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.

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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

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

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

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

## PT Goals

PATIENT-STATED GOAL: add patient-stated goal

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 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 |
|---|---|
| | PAGE 2 of 3 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by JOHNSON, LAURA SN | 05/13/2026 |

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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

| Signature of Physician: | Date |
|---|---|
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