Home Health Certification and Plan of Care

Order ID: 1184/677

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
A04992910	08/12/2026	From: 08/12/2026 To: 10/10/2026	480	037804

6. Patient's Name and Address
Crystal Sanchez
2403 W LOAN CACTUS DR APT 293, MARICOPA,
PHOENIX, AZ 85027-
6029002132

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 05/15/1991 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
F41.9	Anxiety disorder unspecified	08/12/26

13. ICD	Other Pertinent Diagnoses	Date
F20.9	Schizophrenia unspecified	08/12/26
F31.9	Bipolar disorder unspecified	08/12/26
E41.	Nutritional marasmus	08/12/26
J43.9	Emphysema unspecified	08/12/26
J44.89	Other specified chronic obstructive pulmonary disease	08/12/26
K62.3	Rectal prolapse	08/12/26
R15.9	Full incontinence of feces	08/12/26
F17.210	Nicotine dependence cigarettes uncomplicated	08/12/26
Z43.3	Encounter for attention to colostomy	08/12/26
Z79.51	Long term (current) use of inhaled steroids	08/12/26
Z79.899	Other long term (current) drug therapy	08/12/26
Z90.49	Acquired absence of other specified parts of digestive tract	08/12/26

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

Paroxetine - Paroxetine Hydrochloride 20mg by mouth once a day
Levalbuterol Hydrochloride - Levalbuterol Hydrochloride 45 mcg inhalant as necessary prn Q6H
Gabapentin - Gabapentin 300 mg 1 capsule by mouth three times a day 300 mg, Oral, TID
Methocarbamol - Methocarbamol 500 mg 1 tablet by mouth as necessary TID PRN muscle spasm
Ondansetron - Ondansetron 4 mg 1 tablet by mouth as necessary PRN Q6H
Nicotine - Nicotine 2mg by mouth as necessary 2 mg, 1 lozenges, Mucosal, Q2H, PRN nicotine cravings
Aripiprazole - Aripiprazole 5mg by mouth once a day for auditory hallucinations
Fluticasone - Fluticasone Furoate 440mcg inhalant twice a day
Cephalexin - Cephalexin 1 tablet by mouth once a day for UTI
Hydrocodone/Apap - Acetaminophen: Hydrocodone Bitartrate 5/325mg tablets by mouth as necessary Q8H prn pain

14. DME and Supplies:
bath bench, ostomy supplies, cane, Nebulizer

15. Safety Measures:
medication safety, remove environmental barriers, smoke detectors , standard precautions, infectious material management, fall precautions

16. Nutrition:
high protein

17. Allergies:
dupixent, albuterol

18.A. Functional Limitations
Endurance, Bowel/Bladder Incontinence, Ambulation

18.B. Activities Permitted
Up As Tolerated, Cane

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: 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!6. Delusional, hallucinatory, or paranoid behavior, HISTORY OF DEPRESSION: Yes

20. Prognosis: good

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
patient will be responsible for managing treatment

Homebound status: homebound due to generalized weakness, dependence on assistive device and the assistance of another person to leave home

Clinical Condition Requiring Homecare: Patient with history of rectal prolapse, fecal incontinence and recent colostomy creation requires SN assessment for cardiopulmonary, neuro, GI/GU, musculoskeletal and integumentary systems, safety with ADLs and fall precautions, medication and diagnoses management and education, twice per week visits for assitance with ostomy changes and as needed for complications. 8/11/26 - 8/31/26 Patient with history of rectal prolapse, fecal incontinence and recent colostomy creation requires SN assessment for cardiopulmonary, neuro, GI/GU, musculoskeletal and integumentary systems, safety with ADLs and fall precautions, medication and diagnoses management and education, twice per week visits for assitance with ostomy changes and as needed for complications. 9/01/26 - 9/30/26 Patient with history of rectal prolapse, fecal incontinence and recent colostomy creation requires SN assessment for cardiopulmonary, neuro, GI/GU, musculoskeletal and integumentary systems, safety with ADLs and fall precautions, medication and diagnoses management and education, twice per week visits for assitance with ostomy changes and as needed for complications. 10/01/26 - 10/10/26

SN Careplans

SN FREQUENCY: SN 2w8 and prn for ostomy complications or medication changes

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: 4. Multiple emergency department visits (2 or more) in the past 6 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

SN Goals

PATIENT-STATED GOAL: learn to manage ostomy independently

GOALS
patient/caregiver recalls
* prevention exacerbation of anxiety condition including coping patterns
* improved concentration
* strategies to reduce anxiety
* identification of anxiety precipitants, conflicts, and threats
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* ostomy management including how to clean stoma
* change ostomy pouch
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by JOHNSON, LAURA SN on 08/12/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
TAYLOR ALLISON LUKAS
20440 N 27TH AVE
PHOENIX, AZ 85027-3240
PHONE: 480-882-4545 FAX: 14808825814 NPI: 1396114922

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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PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M1720 - Anxiety, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102c - Med Admin, meal preparation, Home Safety, M2020 - Oral Med Management, M1400 - Dyspnea, coughing, M1033 - Exhaustion, constipation, nausea/vomiting, abdominal pain, M1600 - UTI, M1610 - Urinary Incontinence, limited strength, limited endurance, muscle weakness, headache, Pain Effect on Sleep, Pain Interference with ADLs, tooth pain/decay/sensitivity, loss of appetite, irritation/discharge stoma site, M1630 - GI Ostomy, bruising/discoloration

PROCEDURES:

incentive spirometer,

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

apply collection/fistula pouch,

ostomy care & irrigation,

monitor intake & output,

teach/coordinate/arrange medication packaging and/or administration,

coordinate/arrange for maintenance of clean/uncluttered living area

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, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, 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, * ostomy management including how to clean stoma change ostomy pouch, related medication(s) purpose, schedule, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, 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's living environment is clean/uncluttered, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

* 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
* 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
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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
* recalls related medication(s) purpose, schedule

patient's living environment is clean/uncluttered

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	08/12/2026