Home Health Certification and Plan of Care

Order ID: 1184/447

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
A00138984	03/05/2026	From: 03/05/2026 To: 05/03/2026	1412	037804

6. Patient's Name and Address

Martin Miller
9610 N 34th Ave,
PHOENIX, AZ 85051-
480-678-5827

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 01/27/1987 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
Z48.815	Encntr for surgical aftcr following surgery on the dgstv sys	03/05/26

13. ICD	Other Pertinent Diagnoses	Date
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	03/05/26
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	03/05/26
N18.6	End stage renal disease	03/05/26
I82.409	Acute embolism and thombos unsp deep vn unsp lower extremity	03/05/26
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	03/05/26
K59.1	Functional diarrhea	03/05/26
Z99.2	Dependence on renal dialysis	03/05/26
Z79.01	Long term (current) use of anticoagulants	03/05/26
Z79.82	Long term (current) use of aspirin	03/05/26

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

Calcium Acetate - Calcium Acetate 0 667 mg / 1 tablet by mouth three times a day With Meals
Hydralazine Hydrochloride - Hydralazine Hydrochloride 25 mg 25 mg by mouth every 12 hours
Gabapentin - Gabapentin 300 mg 300 mg by mouth every 12 hours
Eliquis - Apixaban 5mg tablet by mouth twice a day for blood thinning (to prevent DVT)
Carvedilol - Carvedilol 12.5 mg 12.5 mg by mouth twice a day
Aspirin 81Mg - Aspirin 81mg tablet by mouth once a day for CAD
Amoxicillin And Clavulanate Potassium - Amoxicillin: Clavulanate Potassium 875 mg;eq 125 mg base 875 mg;eq 125 mg base 1 tablet by mouth every 12 hours for sepsis
Linezolid - Linezolid 600 mg 600 mg 600 mg 1 tablet by mouth every 12 hours for sepsis
Oxycodone Hydrochloride - Oxycodone Hydrochloride 10 mg 10 mg 10 mg 10 mg by mouth as necessary Give 1 tablet by mouth every 4 hours as needed for pain
Sevelamer Carbonate - Sevelamer Carbonate 800 mg by mouth three times a day with meals
Amilodipine - Amlodipine Besylate 0 10 mg/ 1 tablet by mouth once a day
Sennosides - Senna 8.8 MG by mouth at bedtime Give 1 tablet by mouth at bedtime for bowel care: hold for loose stools
Melatonin - Melatonin 0 6mg by mouth at bedtime
Lokelma 0 10 gm by mouth once a day Give 1 packet by mouth one time a day every Tue, Thu, Sat for supplement mix in 4-6oz of beverage
Ondansetron Hydrochloride - Ondansetron Hydrochloride eq 4 mg base eq 4 mg base by mouth as necessary Give 1 tablet by mouth every 6 hours as needed for nausea/vomiting
Diphenhydramine Hydrochloride - Diphenhydramine Hydrochloride 25 mg 25 mg by mouth as necessary t tablet every 6 hours as needed for Itching
Calcium Carbonate (Antacid) 0 500 mg by mouth as necessary Every 6 hours as needed for heartburn
Lactulose - Lactulose 10gm/15ml 0 30 ml by mouth as necessary Give 30 ml by mouth every 24 hours as needed for bowel care

14. DME and Supplies:

wound care supplies, diabetic supplies, cane, bath bench

15. Safety Measures:

walker precautions, fall precautions, diabetic precautions, bleeding precautions, infectious material management, standard precautions, smoke detectors , no bp left arm, medication safety, cardiac precautions, anticoagulant precautions, ambulates with device

16. Nutrition:

diabetic, cardiac diet

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted

Cane, Walker, 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: 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, HISTORY OF DEPRESSION: Yes

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

family/caregiver will be responsible for managing treatment

Homebound status: homebound due to generalized weakness, recent abdominal stab wound with surgical intervention

Clinical Condition Requiring Homecare: SURGICAL AFTERCARE FOLLOWING SURGERY ON THE DIGESTIVE SYSTEM(248.815) Recent surgical patient related to abdominal injury (stabbing) with open mid-abdominal wound requires SN assessment for cardiopulmonary, neuro, GI/GU, musculoskeletal and integumeentary systems, safety with ADLs and fall precautions, medication and diagnoses management and education, wound care per orders twice per weeek and as needed for complications 3/5/26-3/31/26.
 Recent surgical patient related to abdominal injury (stabbing) with open mid-abdominal wound requires SN assessment for cardiopulmonary, neuro, GI/GU, musculoskeletal and integumeentary systems, safety with ADLs and fall precautions, medication and diagnoses management and education, wound care per orders twice per weeek and as needed for complications 4/1/26-4/30/26.
 Recent surgical patient related to abdominal injury (stabbing) with open mid-abdominal wound requires SN assessment for cardiopulmonary, neuro, GI/GU, musculoskeletal and integumeentary systems, safety with ADLs and fall precautions, medication and diagnoses management and education, wound care per orders twice per weeek and as needed for complications 5/1/26-5/3/26.

SN Careplans	SN Goals

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by JOHNSON, LAURA SN on 03/05/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

KELLY ARMENTA
16515 S 40TH ST SUITE 139
PHOENIX, AZ 85048-0558
PHONE: (480) 734 7411 FAX: NPI: 1275872848

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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SN FREQUENCY: SN 1w1, 2w7 and prn for wound complications

CLINICAL FREQUENCY:

SN visit for HH SOC. Wife is primary caregiver and she was present for SOC also. Pt lives in a home with several other families (group home). A&O x4. He has generalized weakness and appears fatigued. He does not use an assistive device and declined a physical therapy referral. There is a walker and cane available in the home if he needs them. He has been a dialysis patient for 6 years and gets dialysis every MWF. Fistula at left arm is currently wrapped due to recent dialysis. Reviewed with pt steps to take in case of bleeding and bleeding precautions. Pt is on blood thinners and antiplatelet medications. He was recently hospitalized following an abdominal stab wound on January 23rd. He spend 2 week at a rehabilitation facility and was discharged home on February 28th. Pt currently has a JP drain. He does not have a way to measure the output but states it gets half full every day. He said he will be going to the doctor tomorrow to have it removed. Nurse demonstrated proper milking of the tubing and pt able to demonstrate that he understands how to milk the tubing properly. Pt does not have a PCP yet but the plan is to obtain a PCP at PIMC. Self reports anxiety and depression. He has a history of diabetes but does not use insulin nor does he check his blood sugar at home. He reports blood sugar levels were wnl while in-patient. Pt c/o pain 7/10 in abdomen. Non-productive cough and lungs are clear throughout. Heart sounds are normal. Bowel sounds active x4 quadrants. History of falls, recent weight loss. Several cavities and missing teeth. Anuric, denies signs of UTI, reports occasional nausea, headaches and diarrhea. Nurse provided education on holding bowel care medication when stools are loose. Currently taking antibiotic for wound infection. Nurse reviewed all medications including his risk medications. Performed wound care per orders to abdominal wound and jp drain site. No signs of infection noted. Abdominal wound is no longer able to be packed. Wound cleansed and dry dressing applied. Home safety assessment complete. Nurse will see pt twice a week beginning next week (T/Th).

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: 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, 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

PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, M1720 - Anxiety, D0160 - Depression, M2102d - Caregiver Performs Treatment, M2102f - Patient Supervision, M2102c - Med Admin, meal preparation, M2020 - Oral Med Management, coughing, abnormal blood pressure, M1033 - Unintentional Weight Loss, M1033 - Exhaustion, M1400 - Dyspnea, abnormal BS < 70/140 > mg/dL, M1620 - Bowel Incontinence, nausea/vomiting, diarrhea, decreased urine output, limited strength, limited endurance, muscle weakness, balance deficit, headache, B1000 - Vision Deficit, Pain Interference with Therapy activities, Pain Effect on Sleep, difficulty sleeping, extremity burn/tingle/numb, Pain Interference with ADLs, tooth pain/decay/sensitivity

PROCEDURES:

physician-ordered wound care: Mid-abdominal wound

Wound care: cleanse with vashe or wound cleanser (use 4x4 gauze and cotton tipped applicator to gently cleanse the area), pat dry with 4x4 gauze, apply calcium alginate to wound bed, cover with 4x4 bordered gauze; Frequency: daily and prn

JP drain site (right abdomen): cleanse insertion site gently with wound cleanser or vashe, pat dry with 4x4 gauze, apply 4x4 split gauze, secure with tape, cover with Suresite 123 transparent film dressing (6x8") before showering Frequency: daily and prn,

monitor intake & output,

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

monitor dialysis schedule

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, * 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, * management of mental health

PATIENT-STATED GOAL: heal wound, no infection

GOALS
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
* 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
* 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
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* 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
* 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 is adequately supervised

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 2 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, 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, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
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