# Home Health Certification and Plan of Care

**Order ID: 1184/721**

| 1. Patient s HI claim No. | 2. Start Of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| A46830002 | 09/03/2026 | From: 09/03/2026 To: 11/01/2026 | 1446 | 037804 |

**6. Patient's Name and Address**
Mark Keltner
4601 E PEBBLE RIDGE RD,
PHOENIX, AZ 85253-
(602)840-8234

**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** 05/22/1972 | **9.Sex** Male

| 11. ICD | Principal Diagnosis | Date |
|---|---|---|
| E10.51 | Type 1 diabetes w diabetic peripheral angiopath w/o gangrene | 09/03/26 |

| 13. ICD | Other Pertinent Diagnoses | Date |
|---|---|---|
| I69.151 | Hemiplga fol ntrm intcrbl hemor aff right dominant side | 09/03/26 |
| I69.120 | Aphasia following nontraumatic intracerebral hemorrhage | 09/03/26 |
| I69.198 | Other sequelae of nontraumatic intracerebral hemorrhage | 09/03/26 |
| G40.909 | Epilepsy unsp not intractable without status epilepticus | 09/03/26 |
| G31.84 | Mild cognitive impairment of uncertain or unknown etiology | 09/03/26 |
| I10. | Essential (primary) hypertension | 09/03/26 |
| K90.0 | Celiac disease | 09/03/26 |
| E78.00 | Pure hypercholesterolemia unspecified | 09/03/26 |
| Z79.82 | Long term (current) use of aspirin | 09/03/26 |
| Z87.01 | Personal history of pneumonia (recurrent) | 09/03/26 |

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

Atenolol - Atenolol 25 mg 1 by mouth once a day
Baclofen - Baclofen 10 mg 1 by mouth three times a day
Levetiracetam - Levetiracetam 500 mg 1 by mouth twice a day
Quinapril Hydrochloride - Quinapril Hydrochloride 20 mg 1 by mouth once a day
Tylenol (Caplet) - Acetaminophen 650 mg 1-2 tabs by mouth as necessary 1-2 tabs as needed for pain
Vitamin D - Ergocalciferol 5000mg by mouth once a day
Coq10 - Coenzyme Q10 200mg by mouth at bedtime
Fish Oil - Cod Liver Oil 1200 mg by mouth once a day
Tresiba - Insulin Degludec 3 units subcutaneous twice a day Degludec Aspart @ 11am 3 units 10-20 min before meal, 3 units @2PM 10-20 minutes before meal.

**14. DME and Supplies:**
wheelchair, diabetic supplies, bath bench, grab bars

**15. Safety Measures:**
diabetic precautions, fall precautions, standard precautions, seizure precautions, activity supervision

**16. Nutrition:**
diabetic, high protein, heart healthy

**17. Allergies:**
no known allergies

**18.A. Functional Limitations**
Speech, Ambulation

**18.B. Activities Permitted**
Up As Tolerated

**19. Mental & Pyschosocial Status:** COGNITION: 2. Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility, ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: No

**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:** Home Health Nursing With medication Management Dx: Cognitive disability, Type I diabetes with insulin use, Hemiplegia

**Clinical Condition Requiring Homecare:** Home Health Nursing With medication Management Dx: Cognitive disability due to stroke/brain injury following MVA, poorly managed Type 1 diabetes, inability to leave home without other person/taxing effort, expressive aphagia, elderly caregiver.

## SN Careplans

SN FREQUENCY: 1W3 and PRN for complications, additional SN visit needs to be assessed after 3 week period and progress with diabetic management.

CLINICAL SUMMARY: Patient seen today for start of care and admission to home health services. Patient with significant prior medical history including stroke at age 30, DM type 1 with insulin use, cognitive deficits, right side hemiplegia, expressive aphagia and hypertension. Medical records indicate Celiac disease but patient and his father report that this is incorrect and patient does not follow a Celiac diet. Several medications listed in medical records are inconsistent with what patient has on his own current medication list. Medications uploaded today are consistent with what patient actually takes daily. SN will follow up with PCP about discrepancies in medication lists. Patient has wheelchair available but refuses to use assistive devices. Recent adjustments made to insulin by endocrinology due to frequent hypoglycemia. Patient uses Freestyle Libre monitor and his blood sugar was 77 then dropped to 66 while speaking with this SN during intake. Patient reports feeling "off" Patient served himself orange juice and by end of SN visit blood sugar was 117. Patient had insulin dosing changed by endocrinology yesterday and patient, father and SN discussed these changes, appropriate diet, interventions for hypoglycemia and managing levels more consistently. Patient and father voiced understanding of instructions provided, SN will continue to reinforce each visit due to patient's cognitive deficits and father's advanced age and management deficits. Home with many fall risks, including multi-level areas, clutter and surfaces with different rugs and items. Father states patient often gets up really fast and "just takes off" and has had multiple non-injury falls but won't use any assistive device for transfers or ambulation. Father states there is another service coming into the home but can't remember the name or specify exactly what services they are providing. Sn requested father request a card or other information from them next time they come to the home so SN can verify services and coordination of care if needed or verify that there isn't duplication of services. Patient will be seen by SN weekly for 3 visits and then assess for continued SN needs, for assessment, diagnoses management and medication management.

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 101, heart rate < 50 > 120,

## SN Goals

PATIENT-STATED GOAL: Be more independent, get blood sugar regulated better

GOALS
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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase socialization
* recalls related medication(s) purpose, schedule

patient's living environment is clean/uncluttered

**23. Signature and Date of Verbal SOC Where Applicable:**
Electronically Signed by DELGADO, MELISSA SN on 09/03/2026

**25. Date HHA Received Signed POT**

**24. Physician's Name and Address**
NADA KRNJAIC
333 E VIRGINIA AVE STE 214
PHOENIX, AZ 85004-1210
PHONE: 602-258-3122 FAX: 16022583119 NPI: 1538345848

**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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respiratory rate < 12 > 29, blood pressure systolic < 85 > 170, blood pressure diastolic < 50 > 90, O2 saturation < 88 > 100, pain < 0 > 8, blood sugar < 60 > 300

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), 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 7. Currently taking 5 or more medications

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: Father states they may the POA info somewhere, but is not for sure.

09/07/2026 Problems : insects/rodents present (CM)
cluttered/soiled living area (CM)
unsafe floor coverings (CM)
M1700 - Cognition
M1720 - Anxiety
D0700 - Social Isolation
M1745 - Behavioral Issues
M1400 - Dyspnea
M2020 - Oral Med Management
weak pulses in feet
delayed capillary refill
abnormal blood pressure
impaired speech
difficulty sleeping
balance deficit
seizures
limited endurance
muscle weakness
pallor
abnormal BS < 70/140 > mg/dL

PROCEDURES: glucose testing via monitor

TEACH PATIENT/CAREGIVER: * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered

| Signature of Physician: | Date |
|---|---|
| | PAGE 2 of 2 |
| Optional Name/Signature of Nurse/Therapist: | Date |
| Electronically Signed by DELGADO, MELISSA SN | 09/03/2026 |