HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1184730

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
9HR5T43WJ59	09/15/2026	09/15/2026 - 11/13/2026	1447	037804

Patient's Name and Address	Gender	Date of Birth	Phone Number
Julia Bode 12374 N 136TH PL SCOTTSDALE, AZ 85259	Female	02/15/1964	602-625-9958
	Email		Primary Language

Clinical Profile

Provider's Name	Address	Phone Number
Devotion Home Health Care, LLC	11201 N Tatum Blvd, Suite 300 Phoenix, AZ 85028	480-415-4423
NPI 1457998957		Fax Number 14809923089

Clinical Condition Requiring Homecare:	Physician Statement on Homebound Status:
Wound Care, Decreased Activity tolerance, immunocompromised and has multiple comorbidities, medically contraindicated and/or difficult to leave the home: Immunosuppressed, SOB with exertion/activity and requires rest periods, Unable to ambulate short distances without rest, and open wounds on her chest.	Because our patient is immunocompromised and has multiple comorbidities.

ICD-10 CM Principal Diagnosis: C50.311. Malig neoplm of lower-inner quadrant of right female breast

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
C79.2	Secondary malignant neoplasm of skin	FOLVITE 1 mg mg Oral daily GLUCOPHAGE 500 mg 1 Oral twice a day take with breakfast and lunch/dinner MULTIVITAMINS 1 tablet Oral daily VITAMIN 2 tablets Oral daily Vitamin D-Vitamin K (Vitamin K2-Vitamin D3 PO D3: 5000 Units K2 100MCg OMEGA-3 1000 MG Oral daily alpelisib (PIQRAY (300 MG DAILY DOSE)) 2 x 150 mg tablet 150 mg / 2 tablet by mouth daily do not break, crush, or chew. Oral chemotherapy-palliative probiotics Take 1 each Oral daily
Z17.0	Estrogen receptor positive status [ER+]	
T45.1X5D	Adverse effect of antineoplastic and immunosup drugs subs	
D64.81	Anemia due to antineoplastic chemotherapy	
L98.9	Disorder of the skin and subcutaneous tissue unspecified	
G62.9	Polyneuropathy unspecified	
D72.825	Bandemia	
F41.9	Anxiety disorder unspecified	
E53.8	Deficiency of other specified B group vitamins	
D69.6	Thrombocytopenia unspecified	
Z90.11	Acquired absence of right breast and nipple	
Z87.891	Personal history of nicotine dependence	
Z48.00	Encounter for change or removal of nonsurg wound dressing	

Prognosis	Mental and Psychosocial Status
poor	COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes
Functional Limitations	**Activities Permitted**
Endurance, Bowel/Bladder Incontinence, Ambulation	Up As Tolerated, ambulation with assistance
DME & Supplies	**Safety Measures**
reacher, urinary/catheter supplies, bath bench, grab bars, commode, wound care supplies, oxygen supplies, motorized scooter	O2 precautions, no bp right arm, fall precautions, ambulates with assistance, standard precautions
Nutrition	**Allergies**
high protein	no known allergies

Bode, Julia | Cert Period 09/15/26 - 11/13/26

Advance Directives	Caregiver Status
No Advance Directive	1. Non-agency caregiver(s) currently provide assistance; 1. Non-agency caregiver(s) currently provide assistance
Rehabilitation Potential	**DISCHARGE PLAN:**
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.	SN: family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

SN CAREPLAN

SN FREQUENCY: 3W9 and PRN for complications.

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

HOSPITALIZATION RISKS: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

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: Living will and Advanced Directives uploaded to patient chart. Patient wishes to sign DNR

09/16/2026 Problems : #1 - Open Wound - Anterior Midline - Large area of wound in varying stages of healing, with large amount of slough, eschar and granulating tissue, some tunneling and strong foul odor. Some areas of tunneling and undermining in left axillary area and right axillary area and under right breast bone area. Unable to fully gauge depth due to significant slough. Moderate amount of drainage consisting of serosanguineous fluid and disintegrating Aquacel Ag material. Several red satellite lesions around wound perimeter. Wound measured as 1 large wound, although it is several wounds now connected.

M1610 - Urinary Incontinence
M1033 - Unintentional Weight Loss
M1033 - Exhaustion
Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
chest pain
daytime fatigue
limited endurance
muscle weakness
poor muscle tone
limited strength
abdominal pain
constipation
loss of appetite
discolored patches of skin
pallor
red/tender pressure points
D0160 - Depression

PROCEDURES: physician-ordered wound care: #1 - Open Wound: Remove old dressing using adhesive remover, apply Lidocaine gel to entire wound bed, apply gauze soaked with Dakin's solution, let sit for 15 minutes, gently clean area removing slough as able, apply No Sting Barrier prep around perimeter of wound, apply Aquacel Ag and Xeroform to wound bed, cover areas of heavy drainage with dry gauze, cover with Kerramax Care Super Absorbent dressings, affix with Hypafix or Medipore tape. Change every other day, more often for saturation or dislodgement.

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, * 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

SN NARRATIVE

Patient seen today for start of care and admission to home health care services. Patient and husband educated on process of admission for home health services for wound care and assessment, services available, medication reconciliation and scheduling of wound care. Patient's spouse reports that patient was seen yesterday at pain management clinic and was prescribed alternate pain medications including fentanyl patches due to current medications causing severe constipation. SN will update EHR with new medications when available from pharmacy and medications are in home. SN also educated patient and spouse about interventions for constipation treatment such as adding in stool softeners daily as well as MiraLAX (or equivalent product) for acute constipation and avoiding laxatives due to cramping and urgency risks. Patient reports that she has a follow-up appointment with oncologist, Dr. Kato on Thursday this week. Patient had last chemotherapy infusion on Thursday last week. Patient and spouse discussed possibility of transitioning to hospice, which has been suggested by oncologist and SN discussed differences between palliative/supportive care and hospice and will provide patient and spouse with some hospice company suggestions to aid family with some decisions. Patient has significant pain constantly in chest area that increases with bathing and dressing changes but is hesitant to use current pain medications in home due to severe constipation issues. SN educated patient and spouse about use of prescription strength Lidocaine gel for dressing changes and will send request for both Colace, MiraLAX and Lidocaine gel to physician. Wound care performed in tandem with patient's spouse, for observation of how he has been performing wound care. Wound is extremely large and irregular in shape and depth, with a strong odor and some areas with significant drainage and others with minimal drainage. Area stretches from right lateral chest, up into axillary area with a tunnel of unknown depth across mid chest and into left axillary area where it has significant depth, slough and strong odor. Several small satellite areas of skin breakdown are present along perimeter of wound. Currently spouse has been removing dressing, placing a single layer of gauze soaked in Dakin's solution over wound, then placing Aquacel Ag and xeroform over entire area, covering with Kerramax absorbent pads and affixing with Hypafix tape and changing daily. Spouse states that they sometimes add crushed Flagyl tablets to some wound areas for "odor" but it is not done every time. SN will verify dosage of this medication and add to EHR if it is going to be incorporated to consistent wound care. SN will add adhesive remover, no sting barrier prep, Lidocaine gel, increased soaking with Dakin's solution and possibly reduction in dressing change frequency to new wound care orders. Vital signs within normal parameters for patient with exception of pain level of 5-6/10 consistently, increasing with dressing changes and when water hits on wound area when bathing. SN proposed a frequency of 3 times a week and as needed for complications for assessment, diagnoses management and wound care and patient and spouse are in agreement with plan of care and voiced understanding of instructions provided.

SN GOALS

PATIENT-STATED GOAL: Improve wound status

GOALS
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

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

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: MELISSA DELGADO SN on 09/15/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services. F2F date: 09/01/2026	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.
Certifying Physician or Allowed Practitioner Name and Address **GIRALDO KATO** 2222 E HIGHLAND AVE STE 400 PHOENIX, AZ 85016-4880 NPI 1285630210	**Phone Number** 602-277-4868 **Fax Number** 16022309350

Physician's Signature and Date Signed

X

GIRALDO KATO, MD
09/01/2026: Date of physician last face-to-face