Order Number:

# HOME HEALTH CERTIFICATION AND PLAN OF CARE 277488

| 1.Patient's HI Claim No. | 2.Start of Care Date | 3. Certification Period | 4. Medical Record No. | 5. Provider No. |
|---|---|---|---|---|
| 999111111A | 4/14/2017 | 4/14/2017 to 6/12/2017 | M0500004573401 | N/A |

6. Patient's Name and Address
MARCIA S TUCZZZKER (111)111-1111
123 MAIN ST.
SANFORD, MI 48657-9515

7. Provider's Name, Address and Telephone Number
HCHB AGENCY16 F: (111)111-1111
123 MAIN ST.
BAY CITY, MI 48706- P: (111)111-1111

8. Date of Birth: 4/9/1935 | 9. Sex [X] M [ ] F

| | | |
|---|---|---|
| 11.ICD-10 | Principal Diagnosis | Date |
| C71.2 | MALIGNANT NEOPLASM OF TEMPORAL LO | 03/11/17 E |
| 12.ICD-10 | Surgical Procedure | Date |
| 13.ICD-10 | Other Pertinent Diagnoses | Date |
| S72.012D | UNSP INTRACAP FX LEFT FEMUR, SUBS | 03/11/17 O |
| R26.81 | UNSTEADINESS ON FEET | 04/14/17 E |
| I48.0 | PAROXYSMAL ATRIAL FIBRILLATION | 03/11/17 E |

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
ACETAMINOPHEN EXTRA STRENGTH ORAL, 500 MG, 2 TABLET, EVERY 6 HOURS/PRN, START 04/01/2017
REASON: PAIN
CHOLECALCIFEROL (VITAMIN D3) ORAL, 1,000 UNIT, 1 TABLET, 2 TIMES DAILY, START 04/01/2017
REASON: SUPPLEMENT
DOCUSATE SODIUM ORAL, 100 MG, 1 TABLET, EVERY PM, START 04/01/2017
REASON: BOWELS
DRONEDARONE ORAL, 400 MG, 1 TABLET, 2 TIMES DAILY, START 04/01/2017
REASON: HEART
GLYCOLAX ORAL, 17 GRAM/DOSE, 1 CAPFUL, DAILY/PRN, START

14. DME and Supplies
NONE

15. Safety Measures:
ANTICOAGULATION PRECAUTIONS, CLEAR PATHWAYS,

16. Nutritional Req. REGULAR DIET

17. Allergies NKA

18.A. Functional Limitations
1. [ ] Amputation
2. [ ] Bowel/Bladder (incontinence)
3. [ ] Contracture
4. [ ] Hearing
5. [ ] Paralysis
6. [X] Endurance
7. [X] Ambulation
8. [ ] Speech
9. [ ] Legally Blind
A. [ ] Dyspnea With Minimal Exertion
B. [ ] Other (Specify)

18.B. Activities Permitted
1. [ ] Complete Bedrest
2. [ ] Bedrest BRP
3. [X] Up As Tolerated
4. [ ] Transfer Bed/Chair
5. [ ] Exercises Prescribed
6. [ ] Partial Wt. Bearing
7. [ ] Independent At Home
8. [ ] Crutches
9. [ ] Cane
A. [X] Wheelchair
B. [X] Walker
C. [ ] No Restrictions
D. [ ] Other (Specify)

19. Mental Status
1. [ ] Oriented
2. [ ] Comatose
3. [ ] Forgetful
4. [ ] Depressed
5. [ ] Disoriented
6. [X] Lethargic
7. [ ] Agitated
8. [ ] Other

20. Prognosis 1. [X] Poor 2. [ ] Guarded 3. [ ] Fair 4. [ ] Good 5. [ ] Excellent

21. Orders of Discipline and Treatments (Specify Amount/Frequency/Duration)
SN 1WK1,2WK2,1WK2
PT EFFECTIVE 04/16/2017 1WK1
OT EFFECTIVE 04/16/2017 1WK1
MSW EFFECTIVE 04/16/2017 1WK1

MED. PWR. OF ATTY

SKILLED NURSE TO EVALUATE AND DEVELOP PLAN OF CARE TO BE COUNTER SIGNED BY PHYSICIAN. SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING S/P AFTER CARE LEFT HIP FRACTURE, A FIB, GLIOBLASTOMA AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS BELOW ATTESTS THAT THESE ORDERS WERE RECEIVED ON 4/14/17 JAMIL NADEEM, MD OFFICE

SKILLED NURSE TO PROVIDE INSTRUCTION RELATED TO GLIOBLASTOMA CANCER DIAGNOSIS INCLUDING PHARMACOLOGICAL AND

22. Goals/Rehabilitation Potential/Discharge Plans
A PLAN OF CARE WILL BE ESTABLISHED THAT MEETS ALL PATIENT'S NURSING NEEDS AND COUNTERSIGNED BY PHYSICIAN. CHANGES IN PATIENT CO-MORBID STATUS WILL BE PROMPTLY IDENTIFIED AND REPORTED TO PHYSICIAN. PATIENT/CAREGIVER WILL VERBALIZE UNDERSTANDING OF THE ABILITY TO PROPERLY MANAGE CO-MORBID CONDITIONS BY 4/30/17
PATIENT/CG WILL VERBALIZE UNDERSTANDING OF INSTRUCTION RELATED TO GLIOBLASTOMA CANCER DIAGNOSIS INCLUDING MEDICATIONS USED TO REDUCE PAIN AND SYMPTOMS BY 4/28/17
CHANGES IN NEUROLOGICAL STATUS WILL BE IDENTIFIED AND REPORTED TO THE PHYSICIAN FOR PROMPT INTERVENTION. PATIENT /

23. Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature)
MARRON BALZZZDWIN, RN / DBA WORKER SCRAMBLE 4/14/2017

25. Date HHA Received Signed POT
1/1/1800

24. Physician's Name & Address
Dr. MARQUITA Z. SEAZZZWELL
4611 CAMPUS RIDGE DRIVE
MIDLAND, MI 48670

26. I certify 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 will periodically review the plan.

27. Attending Physician's Signature and Date Signed
{{SS:#1:signature}}

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.

| ADDENDUM TO: | [X] PLAN OF TREATMENT | [ ] MEDICAL UPDATE |
|---|---|---|

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| 6. Patient's Name | 7. Provider's Name |
|---|---|
| MARCIA S TUCZZZKER | HCHB AGENCY16 |

**10. Medications**

GLYCOLAX ORAL (continued)
04/01/2017
REASON: BOWEL

LACOSAMIDE ORAL, 100 MG, 1 TABLET, 2 TIMES DAILY, START
04/01/2017
REASON: SEIZURE PREVENTION

PANTOPRAZOLE ORAL, 40 MG, 1 TABLET, DAILY, START
04/01/2017
REASON: STOMACH

RIVAROXABAN ORAL, 15 MG, 1 TABLET, EVERY PM, START
04/01/2017
REASON: A FIB

**13. Other Pertinent Diagnoses**

| | | | |
|---|---|---|---|
| ICD-10 (con't) | | | |
| I12.9 | HYPERTENSIVE CHRONIC KIDNEY DISEASE W STG 1-4/UNSP CHR KDNY | 01/01/17 | O |
| N18.3 | CHRONIC KIDNEY DISEASE, STAGE 3 (MODERATE) | 01/01/17 | O |
| Z91.81 | HISTORY OF FALLING | 03/11/17 | O |
| ICD-9 | | | |
| 191.2 | MALIG NEOPLASM TEMPORAL LOBE BRAIN | 04/14/17 | E |
| 781.2 | ABNORMALITY OF GAIT | 04/14/17 | E |
| 585.3 | CHRONIC KIDNEY DISEASE, STAGE III (MODERATE) | 01/01/17 | O |

**15. Safety Measures:**

EMERGENCY PLAN, UNIVERSAL PRECAUTIONS

**21. Orders:**

NON-PHARMACOLOGICAL THERAPIES

SKILLED NURSE TO OBSERVE AND ASSESS NEUROLOGICAL SYSTEM TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO BRAIN CANCER, NUTRITION, MEDICATION REGIMEN AND PERMITTED ACTIVITIES. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN NEUROLOGICAL STATUS TO MD FOR EARLY INTERVENTION.

SKILLED NURSE TO EVALUATE AND PROVIDE EDUCATION ON MANAGEMENT OF UNDERLYING MUSCULOSKELETAL DISEASE PROCESS RELATED TO LEFT HIP FRACTURE.

SKILLED NURSE TO PERFORM/TEACH WOUND CARE TO INCISION SITE LOCATED LEFT HIP: CLEANSE WITH SOAP AND WATER, RINSE, PAT DRY, LEAVE OPEN TO AIR USING CLEAN TECHNIQUE DAILY BY PATIENT/ CAREGIVER / SKILLED NURSE.SKILLED NURSE TO INSTRUCT WOUND CARE FOR CHEST MEDPORT. INSTRUCT PATIENT / CAREGIVER TO CLEANSE WITH SOAP AND WATER, RINSE, PAT DRY, ASSESS SKIN FOR CHANGES DAILY BY PATIENT / CAREGIVER / SKILLED NURSE. MEDPORT MAINTAINED OUTPATIENT.

SKILLED NURSE TO OBSERVE AND ASSESS CARDIOVASCULAR SYSTEM TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO A FIB, HTN, NUTRITION, MEDICATION REGIMEN, PERMITTED ACTIVITIES AND SIGNS / SYMPTOMS TO REPORT.

SKILLED NURSE TO PERFORM OBSERVATION / ASSESSMENT OF GENITOURINARY STATUS AND INTERVENE TO MINIMIZE COMPLICATIONS OF DISEASE PROCESS. SKILLED NURSE TO PROVIDE INSTRUCTION REGARDING MANAGEMENT OF DISEASE PROCESS INCLUDING STAGE III RENAL FAILURE, NUTRITIONAL / FLUID REQUIREMENTS, MEDICATION REGIMEN AND SIGNS / SYMPTOMS TO REPORT.

SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY, NUTRITION, MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PHYSICIAN FOR EARLY INTERVENTION.

SKILLED NURSE FOR OBSERVATION / ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT FOR LEFT HIP FRACTURE AND BRAIN CANCER. SKILLED NURSE TO INTERVENE WITH INCREASED PAIN LEVEL TO MINIMIZE COMPLICATIONS.

SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AT EVERY VISIT. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES.

SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS RELATED TO LEFT HIP FRACTURE, UNSTEADINESS ON FEET. SKILLED NURSE TO INSTRUCT ON HOME SAFETY, IMPACT OF

| 9. Signature of Physician | 10. Date |
|---|---|
| {{SS:#1:signature}} | 1/1/1800 |
| 11. Optional Name/Signature Of | 12. Date |
| MARRON BALZZZDWIN, RN / DBA WORKER SCRAMBLE | 4/14/2017 |

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| MARCIA S TUCZZZKER | HCHB AGENCY16 |

**21. Orders:**

POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION.

PHYSICAL THERAPIST TO EVALUATE TO DETERMINE CONDITION, PHYSICAL THERAPY PLANS AND REHABILITATION POTENTIAL; EVALUATE HOME ENVIRONMENT TO ELIMINATE STRUCTURAL BARRIERS AND IMPROVE SAFETY TO INCREASE FUNCTIONAL INDEPENDENCE (RAMPS, ADAPTIVE WHEELCHAIR, BATHROOM AIDES) AND DEVELOP PHYSICAL THERAPY PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN. THERAPIST MAY PERFORM 02 SATURATION LEVELS AT EVALUATION VISIT AND PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS OR WITH 02 USE.

OCCUPATIONAL THERAPIST TO EVALUATE FOR OT SERVICES AND DEVELOP PLAN OF CARE FOR PHYSICIAN SIGNATURE TO INCLUDE PHYSICAL AND PSYCHOSOCIAL TEST RESULTS, ESTABLISHMENT OF A PLAN OF TREATMENT, REHABILITATION GOALS, AND EVALUATING THE HOME ENVIRONMENT FOR ACCESSIBILITY AND SAFETY AND RECOMMENDING MODIFICATION. THERAPIST MAY PERFORM O2 SATURATION LEVEL AT EVALUATION VISIT AND PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS OR WITH O2 USE.

MEDICAL SOCIAL SERVICES FOR EVALUATION TO ASSESS SOCIAL AND EMOTIONAL FACTORS RELATED TO THE PATIENT'S ILLNESS, NEED FOR CARE, RESPONSE TO TREATMENT AND ADJUSTMENT TO CARE; TO BE FOLLOWED BY COLLABORATION WITH THE PHYSICIAN AND NURSE TO DEVELOP A PLAN OF CARE.

THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS IN BLOCK 23 ATTESTS THAT THE PHYSICIAN'S ORDERS WERE RECEIVED ON 4/14/2017.

LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FALLING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS: TEMP<95>101 PULSE<50>110 RESP<8>29 SYSTOLICBP<88>160 DIASTOLICBP<50>100 FBS<70>300 PAIN>7 O2SAT<89

**22. Goals:**

CAREGIVER WILL VERBALIZE/DEMONSTRATE APPROPRIATE MEASURES TO PROMOTE SAFETY AND PREVENT INJURY. PATIENT / CAREGIVER TO REPORT ANY MENTAL STATUS CHANGES BY 4/30/17
PATIENT/CAREGIVER TO VERBALIZE UNDERLYING MUSCULOSKELETAL DISEASE PROCESS AND METHODS TO MANAGE EXACERBATIONS BY 4/28/17
PATIENT / CAREGIVER WILL VERBALIZE / DEMONSTRATE ABILITY TO PERFORM WOUND CARE. WOUND STATUS WILL IMPROVE AS EVIDENCED BY A DECREASE IN SIZE, DRAINAGE, ABSENCE OF INFECTION, AND DECREASED PAIN BY 4/28/17
CARDIOVASCULAR EXACERBATIONS WILL BE IDENTIFIED PROMPTLY AND INTERVENTIONS INITIATED TO MINIMIZE ASSOCIATED RISK. PATIENT / CAREGIVER WILL VERBALIZE/DEMONSTRATE AN ABILITY TO CARE FOR ALTERED CARDIOVASCULAR STATUS BY END OF EPISODE. PATIENT / CAREGIVER TO VERBALIZE SIGNS / SYMPTOMS TO REPORT INCLUDING IRREGULAR / RAPID HEART RATE, UNCONTROLLED HTN, CHEST PAIN BY 4/28/17
GENITOURINARY SYSTEM WILL BE EVALUATED AND EXACERBATIONS IDENTIFIED WITH INTERVENTIONS IMPLEMENTED TO MINIMIZE COMPLICATIONS. PATIENT / CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY TO CARE FOR ALTERED GENITOURINARY STATUS BY END OF EPISODE. PATIENT / CAREGIVER TO VERBALIZE ANY CHANGES IN URINARY OUTPUT BY 4/28/17
CHANGES IN SKIN INTEGRITY STATUS WILL BE IDENTIFIED AND REPORTED TO THE PHYSICIAN FOR PROMPT INTERVENTION. PATIENT / CAREGIVER WILL VERBALIZE/DEMONSTRATE ADEQUATE KNOWLEDGE OF INTEGUMENTARY STATUS AND APPROPRIATE MEASURES TO PROMOTE SKIN INTEGRITY AND PREVENT INJURY. PATIENT TO HAVE NO SKIN BREADKOWN BY 4/30/17
INCREASED PAIN OR PAIN CONTROL MEASURES WILL BE IDENTIFIED AND PROMPTLY REPORTED TO THE PHYSICIAN. PATIENT / CAREGIVER WILL VERBALIZE UNDERSTANDING OF PHARMACOLOGIC AND NON-PHARMACOLOGIC PAIN CONTROL MEASURES. PATIENT TO HAVE NO PAIN EQUAL TO OR GREATER THAN 5 BY 4/28/17
PATIENT WILL RECEIVE MEDICATIONS AS PRESCRIBED BY PHYSICIAN. CAREGIVER WILL BE ABLE TO NAME MEDICATIONS AND USE BY 4/30/17
PATIENT WILL DEMONSTRATE/VERBALIZE KNOWLEDGE OF INTERVENTIONS TO PREVENT FALLS AND SAFETY HAZARDS. PATIENT WILL REMAIN SAFE WITHIN HOME ENVIRONMENT. PATIENT TO HAVE NO FALLS THROUGH 4/30/17.
A PHYSICAL THERAPY EVALUATION WILL BE COMPLETED AND A PLAN OF CARE TO INCREASE FUNCTIONAL INDEPENDENCE WILL BE ESTABLISHED FOR THE PHYSICIAN'S REVIEW AND SIGNATURE BY 4/28/17
AN OCCUPATIONAL THERAPY EVALUATION WILL BE COMPLETED AND A PLAN OF CARE WILL BE ESTABLISHED FOR THE PHYSICIAN'S SIGNATURE FOR THE ENHANCEMENT OF THE PATIENT'S REHABILITATION POTENTIAL, AND ELIMINATION OF SAFETY HAZARDS TO INCREASE FUNCTIONAL INDEPENDENCE BY 4/28/17
A MEDICAL SOCIAL SERVICES EVALUATION WILL BE COMPLETED AND A PLAN OF CARE WILL BE ESTABLISHED FOR THE PHYSICIAN'S SIGNATURE FOR THE ENHANCEMENT OF THE PATIENT'S SOCIAL AND EMOTIONAL FACTORS, NEED FOR CARE, RESPONSE TO TREATMENT AND ADJUSTMENT TO CARE, TO FOSTER INDEPENDENT LIVING AT HOME BY 4/28/17

**22. Rehab Potential:**

GUARDED/MINIMAL IMPROVEMENT IN FUNCTIONAL STATUS IS EXPECTED; DECLINE IS POSSIBLE

**22. DC Plans:**

DC TO CARE OF FAMILY UNDER SUPERVISION OF MD WHEN GOALS ARE MET

**Supporting Documentation for Home Health Eligibility:**

HOMEBOUND CERTIFICATION

| 9. Signature of Physician | 10. Date |
|---|---|
| {{SS:#1:signature}} | 1/1/1800 |
| 11. Optional Name/Signature Of | 12. Date |
| MARRON BALZZZDWIN, RN / DBA WORKER SCRAMBLE | 4/14/2017 |

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|---|---|
| MARCIA S TUCZZZKER | HCHB AGENCY16 |

I CERTIFY THAT THE ABOVE STATED PATIENT IS HOMEBOUND AND THAT UPON COMPLETION OF THE/THIS F2F ENCOUNTER, HAS A NEED FOR INTERMITTENT SKILLED NURSING, PHYSICAL THERAPY AND/OR SPEECH OR OCCUPATIONAL THERAPY SERVICES IN THEIR HOME FOR THEIR CURRENT DIAGNOSIS AS OUTLINED IN THEIR INITIAL PLAN OF CARE. THESE SERVICES WILL CONTINUE TO BE MONITORED BY MYSELF OR ANOTHER PHYSICIAN WHO WILL PERIODICALLY REVIEW AND UPDATE THE PLAN OF CARE AS REQUIRED.

| 9. Signature of Physician | 10. Date |
|---|---|
| {{SS:#1:signature}} | 1/1/1800 |
| 11. Optional Name/Signature Of | 12. Date |
| MARRON BALZZZDWIN, RN / DBA WORKER SCRAMBLE | 4/14/2017 |