REVIVE HOME HEALTH, INC.

1918 W. Magnolia Blvd., #200 Burbank, CA 91506. Tel: (818) 927-2221, Fax: (818)927-2231

FAX COVER SHEET

TO: Fortaleza, Paul FAX NO: (818)325-2092

FROM: Revive Home Health DATE:

RE:

NO. OF PAGES (including this page):

[X] Urgent [ ] For Review [ ] Please Comment [ ] Please Reply

Please sign and fax it back

Thank you.

REVIVE HOME HEALTH INC.
1918 Magnolia Blvd #200
BURBANK, CA 915061728
Phone: (818) 927-2221 Fax: (818) 927-2231

PHYSICIAN'S ORDER : 10/13/19

ADMISSION

Patient Name (Code)

SARGSYAN, VREZH (37)
14655 BLYTHE ST207

PANORAMA CITY, CA 91402
Phone: (818) 966-1239
DOB: 02/10/1950
Certification Period: 10/13/19 - 12/11/19

Caregiver Name (Code)

MNATSAKANYAN , RUZANNA (42)

Physician Name (Code)

FORTALEZA, PAUL (54)
6350 LAUREL CANYON BLVD
SUITE #205
North Hollywood, CA 91606
Phone: (818) 325-2090
Fax: (818) 325-2092

Notes:

RN reports that patient was admitted to Revive Home Health, Inc. for skilled nursing intervention. Skilled assessment and evaluation was done on all body systems, VS taken and recorded. Patient has significant medical history of Other intervertebral disc degeneration, lumbar region, Chronic obstructive pulmonary disease, Unspecified asthma, uncomplicated, Dependence on supplemental oxygen, Angina pectoris, and Major depressv disorder, recurrent severe w/o psych features. Patient/PCG was also informed of patient rights and responsibilities. PMD informed of patient's present status and condition and proposed plan of care. PMD approved admission and proposed plan of care.

Date and Time of Orders: 10/13/19 4:45 pm

Physician Orders:

Please admit patient to Revive Home Health, Inc. for skilled nursing intervention.

SN VISITS: 2w2, 1w7
RPT: Evaluation and treatment

Facilitate lab works as needed per MD's order; evaluate compliance and response to medication, diet, treatment and education.

Order confirmed, read back.

RN 10/13/19

Staff Signature Date

FORTALEZA, PAUL
6350 LAUREL CANYON BLVD
SUITE #205
North Hollywood, CA 91606

Physician Signature Date

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
616574637B1	10/13/2019	10/13/2019 -12/11/2019	37-003	053125

6. Patient's Name and Address
SARGSYAN, VREZH
14655 BLYTHE ST207
PANORAMA CITY, CA 91402, 818-966-1239

7. Provider's Name, Address, and Telephone Number
REVIVE HOME HEALTH INC.
1918 Magnolia Blvd
#200
BURBANK, CA 91506-1728
818-927-2221
F:818-927-2231

8. Date of Birth: 02/10/1950 | 9. Sex: [X] M [ ] F

11. ICD-10-CM	Principal Diagnosis	Date	E/O
M51.36	Other intervertebral disc	10/13/19	
12. ICD-10-CM	Surgical Procedure	Date	
13. ICD-10-CM	Other Pertinent Diagnoses	Date	
J44.9	Chronic obstructive pulmons	10/13/19	
J45.909	Unspecified asthma, uncompl	10/13/19	
Z99.81	Dependence on supplemental	10/13/19	
I20.9	Angina pectoris, unspecifie	10/13/19	
F33.2	Major depressv disorder, re	10/13/19	

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
ISOSORBIDE MONONITRATE, 60MG, Oral 2 CAPSULE DAILY
ROSUVASTATIN CALCIUM, 10MG, Oral 1 TABLET DAILY
ESCITALOPRAM, 10MG, Oral 1 TABLET DAILY
MECLIZINE HYDROCHLORIDE, 25 MG, Oral 1 TABLET TWICE DAILY
MONTELUKAST SODIUM, EQ 10MG BASE, Oral 1 TABLET DAILY
Please See 487

14. DME and Supplies: Underpads, Gloves (Non-sterile), Cane, Walker, Grab bars, Oxygen

15. Safety Measures: Bleeding precautions, Fall precautions, Clear pathways, Walker, Cane,

16. Nutritional Req.: Low fat, Low cholesterol.

17. Allergies: None Known.

18.A. Functional Limitations
1 [ ] Amputation
2 [X] Bowel/Bladder (Incontinence)
3 [ ] Contracture
4 [X] Hearing
5 [ ] Paralysis
6 [X] Endurance
7 [X] Ambulation
8 [ ] Speech
9 [ ] Legally Blind
A [ ] Dyspnea
B [X] Other (Specify) Poor vision/SOB with min exert

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

19. Mental Status: 1 [X] Oriented 2 [ ] Comatose 3 [X] Forgetful 4 [ ] Depressed 5 [ ] Disoriented 6 [ ] Lethargic 7 [ ] Agitated 8 [X] Other Confused and anxious at times

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

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
Admitted to REVIVE HOME HEALTH INC.
SN frequency: 2w2, 1w7

RPT: Assessment/evaluation to determine home safety, need for therapeutic exercises, transfer/gait training, PCG education /training and establish home exercise program. Plan and frequency of visits to follow post evaluation.

Labs: Per MD's orders.

CERTIFIED for comprehensive skilled nursing assessment, observation and evaluation of musculoskeletal system, pain management and effectiveness, cardiovascular, s/sx hypo/hypertension, endocrine status, respiratory, s/sx of shortness of breath exacerbation, gastrointestinal, genito-urinary, integumentary, s/sx of skin breakdown, neurosensory, mental/emotional, and compliance to prescribed medication/diet regimen.

SN TO ASSESS AND PERFORM EACH VISIT:

22. Goals/Rehabilitation Potential/Discharge Plans
1. Patient will have decreased pain to less than 3/10 through RPT/SN instruction and patient/PCG will verbalize understanding of pain management techniques by the end of 4-6 weeks.

23. Nurse's Signature and Date of Verbal SOC Where Applicable: RN 10/13/2019

25. Date HHA Received Signed POT

24. Physician's Name and Address
FORTALEZA, PAUL MD
6350 LAUREL CANYON BLVD NPI: 1336368190
SUITE #205
North Hollywood, CA 91606 818-325-2090
Fax: (818) 325-2092

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. This patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
A face-to-face patient encounter(s) occurred no more than 90 days prior to or within 30 days after the home health start of care, was related to the primary reason the patient requires home health services, and was performed by either the certifying physician, a physician, with privileges, NP in collaboration with certifying physician, PA or certified nurse midwife under the supervision of a certifying physician who cared for the patient in an acute or post-acute facility from which the patient will be directly admitted to home health. The Face-to-Face encounter:

27. Attending Physicians Signature and Date Signed (Signature applies to all Pages)

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
1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
616574637B1	10/13/2019	10/13/2019 -12/11/2019	37-003	053125

6. Patient's Name and Address	7. Provider's Name, Address, and Telephone Number
SARGSYAN, VREZH 14655 BLYTHE ST207 PANORAMA CITY, CA 91402, 818-966-1239	REVIVE HOME HEALTH INC. 1918 Magnolia Blvd #200 BURBANK, CA 91506-1728 818-927-2221 F:818-927-2231

10. Medications continued

DUTASTERIDE, 0.5MG, Oral IMP
ALBUTEROL SULFATE, 0.5-3 (2.5) MG/3 ML, Oral INHALE 2 PUFFS DAILY AS NEEDED
ISOSORBIDE MONONITRATE, 60MG, Oral 2 CAPSULE DAILY
ROSUVASTATIN CALCIUM, 10MG, Oral 1 TABLET DAILY
ESCITALOPRAM, 10MG, Oral 1 TABLET DAILY
MECLIZINE HYDROCHLORIDE, 25 MG, Oral 1 TABLET TWICE DAILY
MONTELUKAST SODIUM, EQ 10MG BASE, Oral 1 TABLET DAILY
DUTASTERIDE, 0.5MG, Oral IMP
ALBUTEROL SULFATE, 0.5-3 (2.5) MG/3 ML, Oral INHALE 2 PUFFS DAILY AS NEEDED
DONEPEZIL HYDROCHLORIDE, 5MG, Oral 1 TABLET DAILY
MAGNESIUM OXIDE, 400 MG, Oral 1 TABLET DAILY
ATROVENT HFA, 17MCG, Oral INHALE DAILY 1 PUFF AS NEEDED
OXYGEN, USP, 2L/MIN, Oral VENT
VENTOLIN HFA, 90 MCG/200, OralINHALE TWICE A DAILY 2 PUFF AS NEEDED
TAMSULOSIN HYDROCHLORIDE, 0.4MG, Oral 1 TABLET DAILY

14. DME and Supplies continued

concentrator,Nebulizer.

15. Safety Measures continued

Universal Precautions, 911 protocol,Elevate head of bed,911 protocol.

21. Orders for Discipline and Treatments continued

1. VS: Temp/RR/HR/BP check every visit.
2. Scale pain (0-10), implement pain relief measures and evaluate effectiveness.
3. Oxygen saturation level if patient experiences SOB/dyspnea at rest.
4. Assess skin for breakdown (perineal area).

SN TO REPORT THE FOLLOWING PARAMETERS TO PRIMARY PHYSICIAN:
1. Any incidence of falls, injuries, hospitalizations, ER visits.
2. SBP more than 160 mmHg and less than 90 mmHg; DBP more than 90 mmHg and less than 60 mmHg with s/sx of HTN crisis.
3. HR more than 120 bpm and less than 60 bpm.
4. RR more than 24/min and less than 14 /min.
5. Temperature less than 97.0 and more than 100.0 F.
6. Increasing SOB/dyspnea not relieved with rest.
7. Any signs of infection.
8. Any signs/symptoms of adverse responses to medication.
9. Skin integrity impairment.
10. Pain levels elevating 6/10 or greater uncontrolled by analgesic therapy as prescribed.
11. Significant changes in patient's condition.
12. 02 Saturation less than 90%.

SN TO TEACH PATIENT/PCG AND VALIDATE
1. Disease process, diet, activities, and treatment goals.
2. Complex medication management, including schedule, functions, routes, rationale for compliance, possible side effects, and when and what to report to SN and MD.
3. Energy conservation techniques such as pacing of activities and daily rest periods, use of assistive devices, proper body mechanics, safety measures, and fall prevention measures.
4. Specific symptoms necessitating calling the nurse, physician, or 911.
5. Infection control measures, including proper skin care and measures to prevent skin breakdown.
6. Pain management techniques, including rest, relaxation, medication, determining exacerbating factors, and other measures to mitigate pain.

Signs and symptoms of abnormal findings reportable to PMD.

9. Signature of Physician	(Signature applies to all Pages)	10. Date
11. Optional Name/Signature of Nurse/Therapist		12. Date 10/13/19

Form CMS 487 Provider

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22. Goal/Rehabilitation Potential/Discharge Plans continued

2. By the end of RPT services, patient will demonstrate improved tolerance to activities as evidenced by reduction in weakness/fatigue, improved strength/endurance, and ability to perform safe transfer/ambulation with assistive device (cane and walker) and will demonstrate therapeutic/strengthening exercise/proper body mechanics as prescribed by the Physical Therapist.

3. By the end of certification period, patient will maintain stable cardiovascular/respiratory status as evidenced by maintenance of BP within the range of 120-160/60-90mmHg, stable HR between 60-90 beats/minute with regular rate/rhythm, decreased SOB/dyspnea, no chest pain episode; patient will be free of s/sx of bleeding; patient will be free of ER/hospitalization episode.

4. Patient will demonstrate increased safety in ADL/IADLs and ambulation as evidenced by absence of falls/injuries within the certification period. Patient/PCG will verbalize understanding of fall reduction/safety measures by the end of certification period.

5. Patient/PCG will verbalize understanding of proper diet, medication regimen, and s/sx to report to SN/MD by the end of certification period.

6. Patient will remain free of falls, injuries, hospitalizations, and emergency room visits while under Agency care.

99. Item 99

RISK FOR HOSPITALIZATION/ER VISITS: Moderate risk due to altered mental status, high fall risk, complex and high-risk medications.
ACTION: -Pt/PCG education, medication reconciliation every SN visits. Pt is currently taking 5 or more medications
-Teach actions and side effects; teach disease process and s/s of exacerbations of chronic illness; assess pt's ability, knowledge, resources, adhere.
INTERVENTIONS: Closely monitor med compliance as well as developing s/e of medications
MEDICATIONS: Caregiver will be responsible for the administration of medications
PSYCHOSOCIAL: Pt resides at home with Casparyan Avetis as a caregiver 818-966-1239
Demonstrated/Expressed Anxiety, Impaired Decision Making
PREFERRED LANGUAGE: Armenian (Caregiver is present and translating)
PT/CAREGIVER GOALS: Pain to get better
INTERVENTIONS: Provide close assessment and/or evaluation of all body systems.
CULTURE/PREFERENCES: There were no verbalized preferences voiced at this time.
ADVANCED DIRECTIVES: NO - Pt is a FULL CODE
EMERGENCY PREPAREDNESS CODE - 2 caregiver will be responsible for evacuation
LIST OF PHYSICIANS: Paul Fortaleza - Primary Physician
Immunizations: Up to date.

HOMEBOUND STATUS/REASON: Confine to home because of illness; need the aid of supportive devices such as cane/walker; the use of special transportation; or the assistance of another person in order to leave their place of residence.
Patient is homebound for following reasons: 1) Patient needs assistance for all activities. 2) Patient to leave home requires considerable and taxing effort. 3) Patient is unable to safely leave home unassisted. 4) Patient is dependent upon adaptive devices. 5) Patient has SOB upon exertion (minimal). 6) Patient has poor endurance, increased weakness and fatigue.

MENTAL STATUS: Oriented, Forgetful, Confused/Anxious at times.
NEURO/EMOTIONAL/BEHAVIOR/COGNITIVE: Depressed.
CARDIOVASCULAR: Angina pectoris.
VITAL SIGNS: BP Level 130/80, Temperature 98.5 Pulse 78, Respiration 19.
Patient's H/W: weigh 170 LB, height 60 inch.
RESPIRATORY: SOB w/minimal exertion, COPD, Asthma.
GI: Occasionally heartburn.
GU: Urinary incontinence.
ENDOCRINE/METABOLIC: No observable impairment.
MUSCULOSKELETAL: Aching intermittent pain in Back, BLE, pain level 2-7/10.

9. Signature of Physician (Signature applies to all Pages)	10. Date
11. Optional Name/Signature of Nurse/Therapist NS	12. Date 10/13/19

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INTEGUMENTARY STATUS: Good turgor, dry skin.
EENT: Partially impaired/blurred vision. HOH R/L.

FALL RISK: HIGH (8 POINTS)
-educate on fall prevention strategies specific to areas of risk
-monitor areas of risk to reduce fall

DC SUMMARY WILL BE PROVIDED UPON DISCHARGE. AGENCY MAY CARRY OUT ORDERS COMING DIRECTLY FROM OTHER MEDICAL PRACTITIONERS (MD, DO, DPM) WHO MAY BE INVOLVED IN THE CARE OF THE PATIENT
(PLEASE CHECK ONE): [ ] YES, but inform me [ ] NO, please course all orders through me.
Thank you.

9. Signature of Physician (Signature applies to all Pages)

10. Date

11. Optional Name/Signature of Nurse/Therapist

12. Date 10/13/19

Form CMS 487

Provider