

Doctor's Order : 10/24/19
ADMISSION

Patient Name (Code) VYALOVA, VALENTINA (30) 6712 Woodman Ave Apt 98 Van Nuys, CA 91401 Phone: (818) 781-2092 DOB: 09/10/1940 Certification Period: 10/24/19 - 12/22/19	Caregiver Name (Code) AKOPYAN, AIDA (61)	Physician Name (Code) FORTALEZA, PAUL (2) 6350 LAUREL CANYON BLVD SUITE 205 North Hollywood, CA 91606 Phone: (818) 325-2090 Fax: (818) 325-2092
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Notes:

RN reports that patient was admitted to Next-Door Home Care, Inc. for skilled nursing intervention. Skilled assessment and evaluation done on all body systems, VS taken and recorded. Patient was provided with teachings on the disease process, diet and medications. Patient 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.

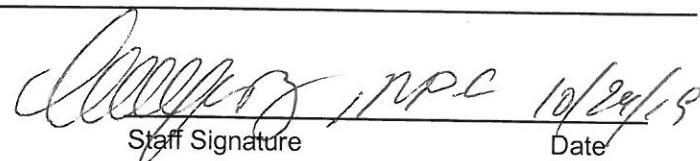
PHYSICIAN'S ORDER:

PLEASE ADMIT PATIENT FOR PERIOD OF: 10/24/19 - 12/22/19

SNV: For skilled nursing intervention and report to MD any significant change in condition, 1wk1, 2wk2, 1wk6

PTV: For evaluation, provide therapeutic intervention, and home safety; report to MD any significant change in condition.

ORDERS READ BACK AND CONFIRMED


Staff Signature Date 10/24/19

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. 609382736M	2. Start Of Care Date 10/24/2019	3. Certification Period 10/24/2019 - 12/22/2019	4. Medical Record No. 000000030-002	5. Provider No. 053186
6. Patient's Name and Address VYALOVA, VALENTINA 6712 Woodman Ave Apt 98 Van Nuys, CA 91401, 818-781-2092			7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-235 F: 818-937-090	
8. Date of Birth 09/10/1940	9. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged Atorvastatin 10 mg one tab by mouth once daily Mapap 500 mg one tab by mouth every 6 hrs as needed for moderate pain Ferosul 325 mg one tab by mouth once daily Clonazepam 0.5 mg one tab by mouth once daily Loratadine 10 mg one tab by mouth once Please See 487		
11. ICD-10-CM M17.4	Principal Diagnosis Other bilateral secondary	Date 10/24/19	E/O	
12. ICD-10-CM	Surgical Procedure	Date		
13. ICD-10-CM M54.5 R26.81 I11.9 D50.9 E03.9 k21.9	Other Pertinent Diagnoses Low back pain Unsteadiness on feet Hypertensive heart disease Iron deficiency anemia, uns Hypothyroidism, unspecified Gastro-esophageal reflux di	Date 10/24/19 10/24/19 10/24/19 10/24/19 10/24/19 10/24/19		
14. DME and Supplies: Non-sterile gloves, incontinent supplies, cane, walker			15. Safety Measures: Fall/Bleeding/Universal Precautions, clear pathways, infection control	
16. Nutritional Req.:NAS, Low fat, Low cholesterol			17. Allergies: Citrus, Flowers	
18.A Functional Limitations 1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind 2 <input checked="" type="checkbox"/> Bowel/Bladder (Incontinence) 6 <input checked="" type="checkbox"/> Endurance A <input type="checkbox"/> Dyspnea 3 <input type="checkbox"/> Contracture 7 <input checked="" type="checkbox"/> Ambulation B <input checked="" type="checkbox"/> Other (Specify) 4 <input checked="" type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech SOB w mod exert, poor vision			18.B Activities Permitted 1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Weight Bearing A <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Independent At Home B <input checked="" type="checkbox"/> Walker 3 <input checked="" type="checkbox"/> Up As Tolerated 8 <input type="checkbox"/> Crutches C <input type="checkbox"/> No Restrictions 4 <input type="checkbox"/> Transfer Bed/Chair 9 <input checked="" type="checkbox"/> Cane D <input checked="" type="checkbox"/> Other (Specify) 5 <input checked="" type="checkbox"/> Exercises Prescribed Assist with ADL's and IADL's	
19. Mental Status 1 <input checked="" type="checkbox"/> Oriented 3 <input checked="" type="checkbox"/> Forgetful 2 <input type="checkbox"/> Comatose 4 <input type="checkbox"/> Depressed			5 <input type="checkbox"/> Disoriented 7 <input type="checkbox"/> Agitated 6 <input type="checkbox"/> Lethargic 8 <input checked="" type="checkbox"/> Other confused, anxious at times	
20. Prognosis 1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded			3 <input checked="" type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input type="checkbox"/> Excellent	
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) PLEASE ADMIT PATIENT FOR PERIOD OF: 10/24/19 - 12/22/19				
<p>SNV: 1wk1, 2wk2, 1wk6 PT: Evaluation and follow up PCG NAME: Veronica (daughter-in-law) PCG PHONE NUMBER: 818 4226638</p> <p>OBSERVE/ASSESS: Homebound status and medical necessity; all body systems with special emphasis on disease process, document, report significant changes in patient's condition to physician including: temperature greater than 100°F, SBP less than 90 or greater than 160, DBP less than 60 or greater than 90, or HR less than 60 or greater than 120, RR less than 14 or greater than 24; Pain over 6/10 on pain scale, and follow orders. SN to assess patient's response and compliance to medication/treatment regimen; teach/instruct/reiterate to patient/caregiver as needed regarding disease management, measures to minimize exacerbation, medication regimen, prescribed diet, fall prevention/safety measures, emergency preparedness, and all other areas of knowledge deficit as identified.</p>				
22. Goals/Rehabilitation Potential/Discharge Plans Patient's status will be monitored; abnormal findings reported to MD and identified HH care needs adequately met. During certification period; Prompt/adequate pain relief will be achieved and maintained within 0-2 (0-10 scale) through pharmacologic or non-pharmacologic measures resulting to increase in mobility, endurance, strength and ability in 4-7 weeks to				
23. Nurse's Signature and Date of Verbal SOC Where Applicable: <i>Veronica, RN</i>			24. Physician's Name and Address FORTALEZA, PAUL 6350 LAUREL CANYON BLVD NPI: 1336368190 SUITE 205 North Hollywood, CA 91606 818-325-2090 Fax: (818) 325-2092	
25. Date HHA Received Signed POT 10/24/2019			26. I certify, <input checked="" type="checkbox"/> 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:

 PLAN OF TREATMENT MEDICAL UPDATE

1. Patient's HI Claim No. 609382736M	2. Start Of Care Date 10/24/2019	3. Certification Period 10/24/2019 -12/22/2019	4. Medical Record No. 000000030-002	5. Provider No. 053186
6. Patient's Name and Address VYALOVA, VALENTINA 6712 Woodman Ave Apt 98 Van Nuys, CA 91401, 818-781-2092		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-235 F:818-937-090		

10. Medications continued
- daily
- Esomeprazole 40 mg one tab by mouth once daily
 Potassium Chl. 8 Meq one tab by mouth once daily
 Clonidine 0.1 mg one tab by mouth every 8 hrs as needed when SBP is more than 160 mmHg
 Vitamin D 50, 000 international Units one tab by mouth once a week
 Furosemide 40 mg one tab by mouth once daily
 Folic Acid 1 mg one tab by mouth once daily
 Levothyroxine 25 mcg one tab by mouth once daily
 Celecoxib 200 mg one tab by mouth once daily
 Vitamin B12 500 mg one tab by mouth once daily
 Metoprolol 25 mg one tab by mouth twice daily
 Amlodipine 5 mg one tab by mouth once daily
 Bayer 81 mg one tab by mouth once daily
 Calcium 600 mg one tab by mouth once daily
13. Other Pertinent Diagnoses continued
- | | | |
|-------|-------------------------------|------------|
| f41.9 | Anxiety disorder, unspecified | 10/24/2019 |
| e78.5 | Hyperlipidemia, unspecified | 10/24/2019 |
15. Safety Measures continued
- measures, Emergency/911 protocols, patient uses cane, walker
21. Orders for Discipline and Treatments continued
- INSTRUCT PATIENT/CAREGIVER: Disease process (Other bilateral secondary osteoarthritis of knee, Low back pain, Unsteadiness on feet, Hypertensive heart disease without heart failure, Iron deficiency anemia, unspecified, Hypothyroidism, unspecified, Gastro-esophageal reflux disease without esophagitis, Anxiety disorder, unspecified, Hyperlipidemia, unspecified); medications (new or changed) as to dosage, route, frequency and adverse effects; diet regimen; pain management; energy conservation measures; coping mechanisms as necessary; home health issues (services, personnel, Patient's Rights, Privacy Act, grievance procedure, DHS hotline, Agency and other numbers to call); home safety (Box 15 above), importance of care plan compliance and to keep all MD appointments; signs and symptoms that need immediate medical attention and when to call MD; emergency procedures and 911 access; ROM exercises; signs and symptoms of hypo/hypertension and measures to take; proper use of DME.
- PT: Evaluation and follow up and set up treatment plan for therapeutic HEP, physical measures and exercises to alleviate pain, equipment needs and training, home safety issues.
- ANCILLARIES as ordered by MD. Notify Agency of significant clinical findings, negative outcomes, medication/service/treatment/personal change, caregiver status, and other relevant matters.
22. Goal/Rehabilitation Potential/Discharge Plans continued
- perform allowed activities within prescribed; Patient will not experience any falls or injury related to unsteady gait during certification period; Cardiovascular status will improve evidenced by adequate Systolic/Diastolic BP control within 120-150/60-90mmHg 7-8 weeks respectively; Patient will experience no signs/symptoms referable to progression or deterioration of iron deficiency/anemia; Patient will experience no general slowing down of body functions referable to Hypothyroidism following regular medication intake; GI status will improve with absence of signs/symptoms referable to Esophageal Reflux including heartburns; Mental status will stabilize with current medication with no evidence of progression or deterioration of Anxiety; Patient will experience no s/s referable to progression or deterioration of Hyperlipidemia; Patient will take all medications as ordered without untoward effects or drug interaction; Patient/caregiver will verbalize or demonstrate understanding and compliance with teachings. Throughout certification period, Patient will remain safe at home free from injury due to fall or other causes.
- REHAB POT: Fair for Patient to achieve partial return to a previous higher level of function.

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

ADDENDUM TO:		<input checked="" type="checkbox"/> PLAN OF TREATMENT	<input type="checkbox"/> MEDICAL UPDATE
1. Patient's HI Claim No. 609382736M	2. Start Of Care Date 10/24/2019	3. Certification Period 10/24/2019 - 12/22/2019	4. Medical Record No. 00000030-002
6. Patient's Name and Address VYALOVA, VALENTINA 6712 Woodman Ave Apt 98 Van Nuys, CA 91401, 818-781-2092		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117	
		818-485-235 F: 818-937-0900	

DC PLAN: To self-care at home with caregiver assist/MD follow up when skilled services no longer needed.

99. Item 99

HOMEBOUND REASON: Considerable and taxing effort to leave home even with assistance of caregiver, required assistance to ambulate, confused, unable to go out of home alone, unable to safely leave home unassisted, SOB upon moderate exertion, dependent upon adaptive devices

NEUROLOGICAL: Forgetful, otherwise alert and oriented, confused/anxious at times. Height: 62 inches, Weight: 190 lbs

CARDIOVASCULAR: Unstable/elevated BP level, non-pitting edema +1 on both ankles.

RESPIRATORY: SOB with moderate exertion

GT: frequent heartburn

GU: Occasional stress incontinence

GU: Occasional stress incontinence
ENDOCRINE/METABOLIC: No complaints at this time

MUSCULOSKELETAL: Aching intermittent pain in Lower back, both knees, intensity 5-6/10, relieved by heat/extension, duration 1-2 days.

rest/relaxation, repositioning,

SKIN/INTEGUMENTARY: Turgor: good

EENT: Partially impaired vision, HOH on both ears

MOUTH: No problem

SELF CARE: Due to forgetfulness, patient non-compliant with pres.

RISK FOR HOSPITALIZATION:
---- Reported/observed history of difficulty complying with any medical instructions in the past 3

Action: Pt/PCG education, medication reconciliation every SN visits. Educate patient/pcg on medication regimen/adverse reactions to report to MD, diet, exercise regimen, medications.

Action: Teach actions and side effects; teach disease process and s/s of exacerbations of chronic illness; assess pt's ability, knowledge, resources. Educate patient on medication regimen/adverse reactions to report to MD, diet, exercise regimen per MD order
----Currently taking 5 or more medications

compliance/regimen and use of me

-----Currently reports exhaustion
Action: PT eval; medications evaluation, pt/cg education on energy conservation

AGENCY MAY CARRY OUT ORDERS COMING DIRECTLY FROM OTHER MEDICAL PRACTITIONERS (MD, DO, DPM) WHOLE

INVOLVED IN THE CARE OF THE PATIENT-----
(X) YES, but inform me

- educate on fall prevention strategies specific to areas of risk

9. Signature of Physician

(Signature applies to all Boxes)

10 Date

11. Optional Name/Signature of Nurse/Therapist

10

Doctor's Order : 10/16/19
ADMISSION

Patient Name (Code)	Caregiver Name (Code)	Physician Name (Code)
MANUKIAN, KNARIK (201) 6525 VANOWEN ST #101	STEPANYAN, MARIA (5)	FORTALEZA, PAUL (2) 6350 LAUREL CANYON BLVD SUITE 205
Van Nuys, CA 91406		North Hollywood, CA 91606
Phone: (818) 987-3932		Phone: (818) 325-2090
DOB: 07/25/1947		Fax: (818) 325-2092
Certification Period:	10/16/19 - 12/14/19	

Notes:

RN reports that patient was admitted to Next-Door Home Care, Inc. for skilled nursing intervention. Skilled assessment and evaluation done on all body systems, VS taken and recorded. Patient was provided with teachings on the disease process, diet and medications. Patient 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.

PHYSICIAN'S ORDER:

PLEASE ADMIT PATIENT FOR PERIOD OF: 10/16/19 – 12/14/19

SNV: For skilled nursing intervention and report to MD any significant change in condition. 2wk3, 1wk3

PTV: For evaluation, provide therapeutic intervention, and home safety; report to MD any significant change in condition.

NOTE: SN has validated patient and patient caregiver competency to perform blood sugar monitoring.

NOTE: Insulin injections done by caregiver, skills validated by RN

ORDERS READ BACK AND CONFIRMED

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. 607163548M	2. Start Of Care Date 10/17/2019	3. Certification Period 10/17/2019 - 12/15/2019	4. Medical Record No. 000000203-001	5. Provider No. 053186
6. Patient's Name and Address KARAPETIAN, MARI 4908 LEXINGTON AVE Los Angeles, CA 90029, 818-640-6516		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-235 F: 818-937-090		
8. Date of Birth 03/08/1927	9. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged Banophen 25 mg 1 tab by mouth twice daily Metoprolol 50 mg 1 tab by mouth daily Vitamin D3 2000 international units 1 tab by mouth daily Fenofibrate 145mg 1 tab by mouth daily Levothyroxine 50 mg 1 tab by mouth daily Aspirin 81 mg 1 tab by mouth daily Amlodipine 10 mg 1 tab by mouth daily Omeprazol 20-100 mg 1 tab by mouth daily Please See 487		
11. ICD-10-CM M17.0	Principal Diagnosis Bilateral primary osteoart	Date 10/17/19	E/O	
12. ICD-10-CM	Surgical Procedure	Date		
13. ICD-10-CM M54.5 M79.641 M79.642 I11.9 E03.9 K21.9	Other Pertinent Diagnoses Low back pain Pain in right hand Pain in left hand Hypertensive heart disease Hypothyroidism, unspecified Gastro-esophageal reflux di	Date 10/17/19 10/17/19 10/17/19 10/17/19 10/17/19 10/17/19		
14. DME and Supplies: Non-sterile gloves, incontinent supplies, cane, walker			15. Safety Measures: Fall/Bleeding/Universal Precautions, clear pathways, infection control	
16. Nutritional Req.: NAS, Low fat, Low cholesterol			17. Allergies: NKA	
18.A. Functional Limitations 1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind 2 <input checked="" type="checkbox"/> Bowel/Bladder (Incontinence) 6 <input checked="" type="checkbox"/> Endurance A <input type="checkbox"/> Dyspnea 3 <input type="checkbox"/> Contracture 7 <input checked="" type="checkbox"/> Ambulation B <input checked="" type="checkbox"/> Other (Specify) 4 <input checked="" type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech SOB w mod exert, poor vision			18.B. Activities Permitted 1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Weight Bearing A <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Independent At Home B <input checked="" type="checkbox"/> Walker 3 <input checked="" type="checkbox"/> Up As Tolerated 8 <input type="checkbox"/> Crutches C <input type="checkbox"/> No Restrictions 4 <input type="checkbox"/> Transfer Bed/Chair 9 <input checked="" type="checkbox"/> Cane D <input checked="" type="checkbox"/> Other (Specify) 5 <input checked="" type="checkbox"/> Exercises Prescribed	
19. Mental Status 1 <input checked="" type="checkbox"/> Oriented 3 <input checked="" type="checkbox"/> Forgetful 2 <input type="checkbox"/> Comatose 4 <input type="checkbox"/> Depressed			Assist with ADL's and IADL's 5 <input type="checkbox"/> Disoriented 7 <input type="checkbox"/> Agitated 6 <input type="checkbox"/> Lethargic 8 <input checked="" type="checkbox"/> Other confused, anxious at times	
20. Prognosis 1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded			3 <input checked="" type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input type="checkbox"/> Excellent	
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) PLEASE ADMIT PATIENT FOR PERIOD OF: 10/17/19 - 12/15/19				
<p>SNV: 1wk1, 2wk2, 1wk6 PT: Evaluation and follow up PCG NAME: Sylva (caregiver) PCG PHONE NUMBER: 818 6406561</p> <p>OBSERVE/ASSESS: Homebound status and medical necessity; all body systems with special emphasis on disease process, document, report significant changes in patient's condition to physician including: temperature greater than 100°F, SBP less than 90 or greater than 160, DBP less than 60 or greater than 90, or HR less than 60 or greater than 120, RR less than 14 or greater than 24; Pain over 6/10 on pain scale, and follow orders. SN to assess patient's response and compliance to medication/treatment regimen; teach/instruct/reiterate to patient/caregiver as needed regarding disease management, measures to minimize exacerbation, medication regimen, prescribed diet, fall prevention/safety measures, emergency preparedness, and all other areas of knowledge deficit as identified.</p>				
22. Goals/Rehabilitation Potential/Discharge Plans Patient's status will be monitored; abnormal findings reported to MD and identified HH care needs adequately met. During certification period; Prompt/adequate pain relief will be achieved and maintained within 0-2 (0-10 scale) through pharmacologic or non-pharmacologic measures resulting to increase in mobility, endurance, strength and ability in 4-5 weeks to				
23. Nurse's Signature and Date of Verbal SOC Where Applicable: <i>[Signature]</i>			25. Date HHA Received Signed POT 10/17/2019	
24. Physician's Name and Address FORTALEZA, PAUL 6350 LAUREL CANYON BLVD NPI: 1336368190 SUITE 205 North Hollywood, CA 91606 818-325-2090 Fax: (818) 325-2092			26. I certify XXXXXX 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:

 PLAN OF TREATMENT MEDICAL UPDATE

1. Patient's HI Claim No. 607163548M	2. Start Of Care Date 10/17/2019	3. Certification Period 10/17/2019 - 12/15/2019	4. Medical Record No. 000000203-001	5. Provider No. 053186
6. Patient's Name and Address KARAPETIAN, MARI 4908 LEXINGTON AVE Los Angeles, CA 90029, 818-640-6516		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-235 F:818-937-090		

10. Medications continued
Azelastine 0.05% eye drops 1 drop to both eyes twice daily
Ibuprofen 800 mg 1 tab by mouth daily
13. Other Pertinent Diagnoses continued
E78.5 Hyperlipidemia, unspecified 10/17/2019
15. Safety Measures continued
measures, Emergency/911 protocols, patient uses cane, walker
21. Orders for Discipline and Treatments continued
INSTRUCT PATIENT/CAREGIVER: Disease process (Bilateral primary osteoarthritis of knee, Low back pain, , Pain in right hand, Pain in left hand, Hypertensive heart disease without heart failure, Hypothyroidism, unspecified, Gastro-esophageal reflux disease without esophagitis, Hyperlipidemia, unspecified); medications (new or changed) as to dosage, route, frequency and adverse effects; diet regimen; pain management; energy conservation measures; coping mechanisms as necessary; home health issues (services, personnel, Patient's Rights, Privacy Act, grievance procedure, DHS hotline, Agency and other numbers to call); home safety (Box 15 above), importance of care plan compliance and to keep all MD appointments; signs and symptoms that need immediate medical attention and when to call MD; emergency procedures and 911 access; ROM exercises; signs and symptoms of hypo/hypertension and measures to take; proper use of DME.
PT: Evaluation and follow up and set up treatment plan for therapeutic HEP, physical measures and exercises to alleviate pain, equipment needs and training, home safety issues.
ANCILLARIES as ordered by MD. Notify Agency of significant clinical findings, negative outcomes, medication/service/treatment/personal change, caregiver status, and other relevant matters.
22. Goal/Rehabilitation Potential/Discharge Plans continued
perform allowed activities within prescribed; Cardiovascular status will improve evidenced by adequate Systolic/Diastolic BP control within 120-150/60-90mmHg 7-8 weeks respectively; Patient will experience no general slowing down of body functions referable to Hypothyroidism following regular medication intake; GI status will improve with absence of signs/symptoms referable to Esophageal Reflux including heartburns; Patient will experience no s/s referable to progression or deterioration of Hyperlipidemia; Patient will take all medications as ordered without untoward effects or drug interaction; Patient/caregiver will verbalize or demonstrate understanding and compliance with teachings. Throughout certification period, Patient will remain safe at home free from injury due to fall or other causes.
- REHAB POT: Fair for Patient to achieve partial return to a previous higher level of function.
- DC PLAN: To self-care at home with caregiver assist/MD follow up when skilled services no longer needed.
99. Item 99
HOMEBOUND REASON: Considerable and taxing effort to leave home even with assistance of caregiver, required assistance to ambulate, confused, unable to go out of home alone, unable to safely leave home unassisted, SOB upon moderate exertion, dependent upon adaptive devices
NEUROLOGICAL: Forgetful, otherwise alert and oriented, confused/anxious at times. Height: 62 inches, Weight: 165 lbs
CARDIOVASCULAR: Unstable/elevated BP level, No Edema
RESPIRATORY: SOB with moderate exertion
GI: No complaints at this time
GU: Incontinent during the day and night
ENDOCRINE/METABOLIC: No complaints at this time
MUSCULOSKELETAL: Aching intermittent pain in both knees, hands, lower back, intensity 5-6/10,

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

ADDENDUM TO:		<input checked="" type="checkbox"/> PLAN OF TREATMENT	<input type="checkbox"/> MEDICAL UPDATE
1. Patient's HI Claim No. 607163548M	2. Start Of Care Date 10/17/2019	3. Certification Period 10/17/2019 - 12/15/2019	4. Medical Record No. 000000203-001
6. Patient's Name and Address KARAPETIAN, MARI 4908 LEXINGTON AVE Los Angeles, CA 90029, 818-640-6516		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117	
		818-485-235 F:818-937-090	

relieved by rest/relaxation, repositioning, medications
SKIN/INTEGUMENTARY: Turgor: good
EENT: Partially impaired vision, HOH on both ears
MOUTH: Dentures: upper, lower
SELF CARE: Due to forgetfulness, patient non-compliant with prescribed medications, dependent on others in all activities of daily living and medical regimen management
SAFETY CONCERNS/ FUNCTIONAL LIMITATIONS: Limited in ADLs, mobility, ambulation/transfers
PSYCHOSOCIAL STATUS: Lives alone with regular daytime assistance

RISK FOR HOSPITALIZATION:

-----History of falls (2 or more falls, or any fall with any injury - in the past 12 months)
Action: Measures to prevent falls, injuries and hospitalization

----- Reported/observed history of difficulty swallowing

----- Reported/observed history of difficulty complying with any medical instructions in the past 3 months

Action: Pt/PCG education, medication reconciliation every SN visits. Educate patient/pcg on medication regimen/adverse reactions to report to MD, diet, exercise regimen per MD order

-----Currently taking 5 or more medications
Action: Teach actions and side effects; teach disease process and s/s of exacerbations chronic illness; assess pt's ability, knowledge, resources. Educate patient on medication compliance/regimen and use of medical ID bracelet

-----Currently reports exhaustion

Action: PT eval; medications evaluation, pt/cg education on energy conservation techniques/relaxation techniques

AGENCY MAY CARRY OUT ORDERS COMING DIRECTLY FROM OTHER MEDICAL PRACTITIONERS (MD, DO, DPM) WHILE INVOLVED IN THE CARE OF THE PATIENT. (PLEASE CHECK ONE)

INVOLVED IN THE CARE OF THE PATIENT-----
(X) YES, but inform me
DISCHARGE SLIP MARK NUMBERABLE UPON PATIENT

FAIL RISK: MEDIUM (3)

- educate on fall prevention strategies specific to areas of risk
 - monitor areas of risk to evaluate fall prevention effectiveness

9. Signature of Physician

(Signature applies to all Pages)

10 Date

11. Optional Name/Signature of Nurse/Therapist

12. Date

Doctor's Order : 10/17/19
ADMISSION

Patient Name (Code) KARAPETIAN, MARI (203) 4908 LEXINGTON AVE Los Angeles, CA 90029 Phone: (818) 640-6516 DOB: 03/08/1927 Certification Period: 10/17/19 - 12/15/19	Caregiver Name (Code) STEPANYAN, MARIA (5)	Physician Name (Code) FORTALEZA, PAUL (2) 6350 LAUREL CANYON BLVD SUITE 205 North Hollywood, CA 91606 Phone: (818) 325-2090 Fax: (818) 325-2092
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Notes:

RN reports that patient was admitted to Next-Door Home Care, Inc. for skilled nursing intervention. Skilled assessment and evaluation done on all body systems, VS taken and recorded. Patient was provided with teachings on the disease process, diet and medications. Patient 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.

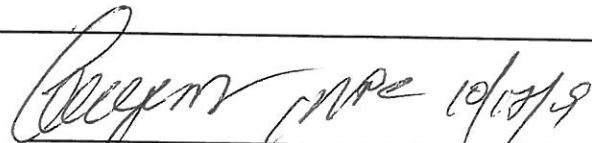
PHYSICIAN'S ORDER:

PLEASE ADMIT PATIENT FOR PERIOD OF: 10/17/19 – 12/15/19

SNV: For skilled nursing intervention and report to MD any significant change in condition, 1wk1, 2wk2, 1wk6

PTV: For evaluation, provide therapeutic intervention, and home safety; report to MD any significant change in condition.

ORDERS READ BACK AND CONFIRMED

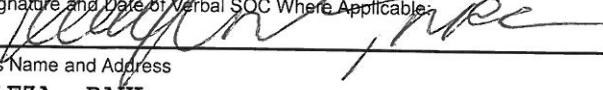

Signature 10/17/19
Staff Signature Date

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. 608098869M	2. Start Of Care Date 10/16/2019	3. Certification Period 10/16/2019 - 12/14/2019	4. Medical Record No. 000000201-001
6. Patient's Name and Address MANUKIAN, KNARIK 6525 VANOWEN ST #101 Van Nuys, CA 91406, 818-987-3932		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-235 F: 818-937-090	
8. Date of Birth 07/25/1947	9. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged Lorazepam 1 mg 1 tab by mouth daily NovoLog 100 U/mL 6 units injection subcutaneously daily Ibuprofen 600 mg 1 tab by mouth daily Metformin 850 mg 1 tab by mouth daily Januvia 100 mg 1 tab by mouth daily Sertraline 50 mg 1 tab by mouth daily Magnesium oxide 1 tab by mouth daily Ezetimibe 10 mg 1 tab by mouth daily Please See 487	
11. ICD-10-CM M17.4	Principal Diagnosis Other bilateral secondary	Date 10/16/19	E/O
12. ICD-10-CM	Surgical Procedure	Date	
13. ICD-10-CM M54.5 E11.65 I11.9 E03.9 F32.9 e78.5	Other Pertinent Diagnoses Low back pain Type 2 diabetes mellitus w/ Hypertensive heart disease Hypothyroidism, unspecified Major depressive disorder, Hyperlipidemia, unspecified	Date 10/16/19 10/16/19 10/16/19 10/16/19 10/16/19 10/16/19	
14. DME and Supplies: Non-sterile gloves, incontinent supplies, DM supplies, alcohol swabs, cane,		15. Safety Measures: Fall/Bleeding/Universal Precautions, clear pathways, infection control	
16. Nutritional Req.:NAS, Low fat, Low cholesterol,			
17. Allergies: NKA			
18.A Functional Limitations	1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind 2 <input checked="" type="checkbox"/> Bowel/Bladder (Incontinence) 6 <input checked="" type="checkbox"/> Endurance A <input type="checkbox"/> Dyspnea 3 <input type="checkbox"/> Contracture 7 <input checked="" type="checkbox"/> Ambulation B <input checked="" type="checkbox"/> Other (Specify) 4 <input checked="" type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech SOB w mod exert, poor vision	18.B Activities Permitted	1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Weight Bearing A <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Independent At Home B <input checked="" type="checkbox"/> Walker 3 <input checked="" type="checkbox"/> Up As Tolerated 8 <input type="checkbox"/> Crutches C <input type="checkbox"/> No Restrictions 4 <input type="checkbox"/> Transfer Bed/Chair 9 <input checked="" type="checkbox"/> Cane D <input checked="" type="checkbox"/> Other (Specify) 5 <input checked="" type="checkbox"/> Exercises Prescribed
19. Mental Status	1 <input checked="" type="checkbox"/> Oriented 3 <input checked="" type="checkbox"/> Forgetful 2 <input type="checkbox"/> Comatose 4 <input checked="" type="checkbox"/> Depressed	5 <input type="checkbox"/> Disoriented 7 <input type="checkbox"/> Agitated 6 <input type="checkbox"/> Lethargic 8 <input checked="" type="checkbox"/> Other	confused, anxious at times
20. Prognosis	1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded 3 <input checked="" type="checkbox"/> Fair	4 <input type="checkbox"/> Good	5 <input type="checkbox"/> Excellent
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) PLEASE ADMIT PATIENT FOR PERIOD OF: 10/16/19 - 12/14/19			
SNV: 2wk2, 1wk7 PT: Evaluation and follow up PCG NAME: Gevorg (caregiver) PCG PHONE NUMBER: 702 8833944			
OBSERVE/ASSESS: Homebound status and medical necessity; all body systems with special emphasis on disease process, document, report significant changes in patient's condition to physician including: temperature greater than 100°F, SBP less than 90 or greater than 160, DBP less than 60 or greater than 90, or HR less than 60 or greater than 120, RR less than 14 or greater than 24; BS less than 60mg/dl or greater than 300mg/dl or for any signs and symptoms of hypo/hyperglycemia and follow orders. Pain over 6/10 on pain scale, and follow orders. SN to assess patient's response and compliance to medication/treatment regimen; teach/instruct/reiterate to patient/caregiver as needed regarding disease management, measures to minimize exacerbation, medication regimen, prescribed diet, fall prevention/safety measures, emergency preparedness, and all other areas of knowledge deficit as identified.			
22. Goals/Rehabilitation Potential/Discharge Plans Patient's status will be monitored; abnormal findings reported to MD and identified HH care needs adequately met. During certification period; Prompt/adequate pain relief will be achieved and maintained within 0-2 (0-10 scale) through pharmacologic or non-pharmacologic measures resulting to increase in mobility, endurance, strength and ability in 4-5 weeks to		23. Nurse's Signature and Date of Verbal SOC Where Applicable  10/16/2019	
24. Physician's Name and Address FORTALEZA, PAUL 6350 LAUREL CANYON BLVD SUITE 205 North Hollywood, CA 91606 818-325-2090 Fax: (818) 325-2092		25. Date HHA Received Signed POT 10/16/2019	
27. Attending Physicians Signature and Date Signed (Signature applies to all Pages)		28. I certify <input checked="" type="checkbox"/> 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: 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:

PLAN OF TREATMENT

MEDICAL UPDATE

1. Patient's HI Claim No.

608098869M

2. Start Of Care Date

10/16/2019

3. Certification Period

10/16/2019 - 12/14/2019

4. Medical Record No.

000000201-001

5. Provider No.

053186

6. Patient's Name and Address

MANUKIAN, KNARIK
6525 VANOWEN ST #101
Van Nuys, CA 91406, 818-987-39327. Provider's Name, Address, and Telephone Number
Next Door Home Care, Inc.
412 W. Broadway Suite 305
Glendale, CA 91204-4117818-485-23
F:818-937-09

10. Medications continued

Glipizide 4 mg 1 tab by mouth daily
FlexTouch 24 units injection subcutaneously daily at bedtime
Victoza 18 mg/3ml 1.2 units injection subcutaneously
Vitamin D2 1.25mg 1 tab by mouth once weekly
Fenofibrate 134 mg 1 tab by mouth daily
Atorvastatin 20 mg 1 tab by mouth daily
Amlodipine 5 mg 1 tab by mouth daily
Losartan HCTZ 50-125 mg 1 tab by mouth daily
Fluticasone nasal spray 50 mg 1 spray for each nostril
Vascepa 1 gm 1 tab by mouth 3 times daily

14. DME and Supplies continued

walker

15. Safety Measures continued

measures, Emergency/911 protocols, patient uses cane, walker

16. Nutrition Req. continued

Controlled Carbohydrate,

21. Orders for Discipline and Treatments continued

INSTRUCT PATIENT/CAREGIVER: Disease process and related issues (signs and symptoms, complications, treatment); medications as to dosage, route, frequency and adverse effects; diet regimen; pain management; energy conservation measures; coping mechanisms as necessary; home health issues (services, personnel, Patient's Rights, Privacy Act, grievance procedure, DHS hotline, Agency and other numbers to call); home safety (Box 15 above), importance of care plan compliance and to keep all MD appointments; signs and symptoms that need immediate medical attention and when to call MD; emergency procedures and 911 access; diabetes skin/foot care, safe disposal of sharps and contaminated materials; ROM exercises; signs and symptoms of hypo/hypertension; hypo/hyperglycemia and measures to take; proper use of DME.

PT: Evaluation and follow up and set up treatment plan for therapeutic HEP, physical measures and exercises to alleviate pain, equipment needs and training, home safety issues.

ANCILLARIES as ordered by MD. Notify Agency of significant clinical findings, negative outcomes, medication/service/treatment/personal change, caregiver status, and other relevant matters.

NOTE: SN has validated patient and patient caregiver competency to perform blood sugar monitoring.
NOTE: Insulin injections done by caregiver, skills validated by RN

22. Goal/Rehabilitation Potential/Discharge Plans continued

perform allowed activities within prescribed; Patient will maintain strict compliance with current DM regimen evidenced by regular and timely insulin injections, appropriate diet/activities and adequate BS control between 80-150 mg/dl without any complication(s) including hypo-hyperglycemia. Patient will also continue to verbalize signs/symptoms of hypo-hyperglycemia & its management & maintain knowledge re: diabetic regimen, BS monitoring using aseptic technique, reportable parameters, and proper skin and foot care; Cardiovascular status will improve evidenced by adequate Systolic/Diastolic BP control within 120-150/60-90mmHg 7-8 weeks respectively; Patient will experience no general slowing down of body functions referable to Hypothyroidism following regular medication intake; Patient will demonstrate stable mental status characterized by reduction of Depression, improved sleeping pattern, social interaction and coping; Patient will experience no s/s referable to progression or deterioration of Hyperlipidemia; Patient will take all medications as ordered without untoward effects or drug interaction; Patient/caregiver will verbalize or demonstrate understanding and compliance with teachings. Throughout certification period, Patient will remain safe at home free from injury due to fall or other causes.

9. Signature of Physician

(Signature applies to all Pages)

10. Date

11. Optional Name/Signature of Nurse/Therapist

12. Date

Form CMS 487

Provider

Page 2 of 3

Doctor's Order : 10/11/19
ADMISSION

Patient Name (Code)	Caregiver Name (Code)	Physician Name (Code)
TOPCHYAN, OGANES (202) 15046 GAULT ST	STEPANYAN, MARIA (5)	FORTALEZA, PAUL (2) 6350 LAUREL CANYON BLVD SUITE 205
Van Nuys, CA 91405		North Hollywood, CA 91606
Phone: (818) 926-1620		Phone: (818) 325-2090
DOB: 02/10/1940		Fax: (818) 325-2092
Certification Period:	10/11/19 - 12/09/19	

Notes:

RN reports that patient was admitted to Next-Door Home Care, Inc. for skilled nursing intervention. Skilled assessment and evaluation done on all body systems, VS taken and recorded. Patient was provided with teachings on the disease process, diet and medications. Patient 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.

PHYSICIAN'S ORDER:

PLEASE ADMIT PATIENT FOR PERIOD OF: 10/11/19 – 12/09/19

SNV: For skilled nursing intervention and report to MD any significant change in condition. 1wk1, 2wk2, 1wk3

PTV: For evaluation, provide therapeutic intervention, and home safety; report to MD any significant change in condition.

ORDERS READ BACK AND CONFIRMED

Deegan, pre 10/14/11
Staff Signature Date

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. 606169813M	2. Start Of Care Date 10/11/2019	3. Certification Period 10/11/2019 - 12/09/2019	4. Medical Record No. 000000202-001	5. Provider No. 053186
6. Patient's Name and Address TOPCHYAN, OGANES 15046 GAULT ST Van Nuys, CA 91405, 818-926-1620		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-235 F:818-937-090		
8. Date of Birth 02/10/1940	9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged Ibuprofen 800mg tab by mouth daily Hydrocortisone 1% cream apply to effectead area every 4 hrs. Naproxen 500mg 1 tab by mouth twice daily Rosuvastatin 20mg 1 tab by mouth daily Atenolol 25 mg 1 tab by mouth daily Cyclobenzaprine 10 mg 1 tab by mouth daily Clopidogrel 75 mg 1 tab by mouth daily Please See 487		
11. ICD-10-CM M17.4	Principal Diagnosis Other bilateral secondary	Date 10/11/19	E/O	
12. ICD-10-CM	Surgical Procedure	Date		
13. ICD-10-CM M54.5 M54.2 I11.9 I25.119 K21.9 N40.0	Other Pertinent Diagnoses Low back pain Cervicalgia Hypertensive heart disease Athscl heart disease of nat Gastro-esophageal reflux di Benign prostatic hyperplas	Date 10/11/19 10/11/19 10/11/19 10/11/19 10/11/19 10/11/19		
14. DME and Supplies: Non-sterile gloves, incontinent supplies, cane		15. Safety Measures: Fall/Bleeding/Universal Precautions, clear pathways, infection control		
16. Nutritional Req.:NAS, Low fat, Low cholesterol				
17. Allergies: NKA				
18.A. Functional Limitations 1 <input type="checkbox"/> Amputation 2 <input checked="" type="checkbox"/> Bowel/Bladder (Incontinence) 3 <input type="checkbox"/> Contracture 4 <input checked="" type="checkbox"/> Hearing	5 <input type="checkbox"/> Paralysis 6 <input checked="" type="checkbox"/> Endurance 7 <input checked="" type="checkbox"/> Ambulation 8 <input type="checkbox"/> Speech	9 <input type="checkbox"/> Legally Blind A <input type="checkbox"/> Dyspnea B <input checked="" type="checkbox"/> Other (Specify) SOB w mod exert, poor vision	18.B. Activities Permitted 1 <input type="checkbox"/> Complete Bedrest 2 <input type="checkbox"/> Bedrest BRP 3 <input checked="" type="checkbox"/> Up As Tolerated 4 <input type="checkbox"/> Transfer Bed/Chair 5 <input checked="" type="checkbox"/> Exercises Prescribed	A <input type="checkbox"/> Wheelchair B <input type="checkbox"/> Walker C <input type="checkbox"/> No Restrictions D <input checked="" type="checkbox"/> Other (Specify) Assist with ADL's and IADL's
19. Mental Status 1 <input checked="" type="checkbox"/> Oriented 2 <input type="checkbox"/> Comatose	3 <input checked="" type="checkbox"/> Forgetful 4 <input type="checkbox"/> Depressed	5 <input type="checkbox"/> Disoriented 6 <input type="checkbox"/> Lethargic	7 <input type="checkbox"/> Agitated 8 <input checked="" type="checkbox"/> Other	confused, anxious at times
20. Prognosis 1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded	3 <input checked="" type="checkbox"/> Fair	4 <input type="checkbox"/> Good	5 <input type="checkbox"/> Excellent	
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) PLEASE ADMIT PATIENT FOR PERIOD OF: 10/11/19 - 12/09/19				
SNV: 1wk1, 2wk2, 1wk6 PT: Evaluation and follow up PCG NAME: Gevorg (son) PCG PHONE NUMBER: 818 3812020				
OBSERVE/ASSESS: Homebound status and medical necessity; all body systems with special emphasis on disease process, document, report significant changes in patient's condition to physician including: temperature greater than 100oF, SBP less than 90 or greater than 160, DBP less than 60 or greater than 90, or HR less than 60 or greater than 120, RR less than 14 or greater than 24; Pain over 6/10 on pain scale, and follow orders. SN to assess patient's response and compliance to medication/treatment regimen; teach/instruct/reiterate to patient/caregiver as needed regarding disease management, measures to minimize exacerbation, medication regimen, prescribed diet, fall prevention/safety measures, emergency preparedness, and all other areas of knowledge deficit as identified.				
22. Goals/Rehabilitation Potential/Discharge Plans Patient's status will be monitored; abnormal findings reported to MD and identified HH care needs adequately met. During certification period; Prompt/adequate pain relief will be achieved and maintained within 0-2 (0-10 scale) through pharmacologic or non-pharmacologic measures resulting to increase in mobility, endurance, strength and ability in 4-5 weeks to				
23. Nurse's Signature and Date of Verbal SOC Where Applicable: 		25. Date HHA Received Signed POT 10/11/2019		
24. Physician's Name and Address FORTALEZA, PAUL 6350 LAUREL CANYON BLVD SUITE 205 North Hollywood, CA 91606 818-325-2090 Fax: (818) 325-2092		26. I certify <input checked="" type="checkbox"/> 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:

 PLAN OF TREATMENT MEDICAL UPDATE

1. Patient's HI Claim No. 606169813M	2. Start Of Care Date 10/11/2019	3. Certification Period 10/11/2019 - 12/09/2019	4. Medical Record No. 000000202-001	5. Provider No. 053186
6. Patient's Name and Address TOPCHYAN, OGANES 15046 GAULT ST Van Nuys, CA 91405, 818-926-1620		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-235 F:818-937-090		

10. Medications continued

Doxazosin 4 mg 1 tab by mouth daily
 Creon 24.000 units 1 tab by mouth daily
 Esomeprazole 40 mg 1 tab by mouth daily
 Voltaren 1% gel apply to effected area daily
 Fluticasone 50mg nasal spray 1 spray to each nostril daily
 Olmesartan 40/10/25 mg 1 tab by mouth daily
 Vascepa 1 gm 3 tab by mouth daily
 Nitroglycerin 0.4 mg 1 tab as needed for chest pain may repeat 3 times with 5 minutes interval if not relieve, call 911
 Triamcinolone 0,5% cream apply to affected area daily
 Aspirin 81 mg 1 tab by mouth daily
 Vitamin D 50000 international units 1 tab by mouth weekly

13. Other Pertinent Diagnoses continued

E78.5 Hyperlipidemia, unspecified

10/11/2019

15. Safety Measures continued

measures, Emergency/911 protocols, patient uses cane

21. Orders for Discipline and Treatments continued

INSTRUCT PATIENT/CAREGIVER: Disease process (Other bilateral secondary osteoarthritis of knee, Low back pain, Cervicalgia, Hypertensive heart disease without heart failure, Atherosclerotic heart disease of native coronary art w unsp ang pctrs, Gastro-esophageal reflux disease without esophagitis, Benign prostatic hyperplasia without lower urinary tract symp, Hyperlipidemia, unspecified); medications (new or changed) as to dosage, route, frequency and adverse effects; diet regimen; pain management; energy conservation measures; coping mechanisms as necessary; home health issues (services, personnel, Patient's Rights, Privacy Act, grievance procedure, DHS hotline, Agency and other numbers to call); home safety (Box 15 above), importance of care plan compliance and to keep all MD appointments; signs and symptoms that need immediate medical attention and when to call MD; emergency procedures and 911 access; ROM exercises; signs and symptoms of hypo/hypertension and measures to take; proper use of DME.

PT: Evaluation and follow up and set up treatment plan for therapeutic HEP, physical measures and exercises to alleviate pain, equipment needs and training, home safety issues.

ANCILLARIES as ordered by MD. Notify Agency of significant clinical findings, negative outcomes, medication/service/treatment/personal change, caregiver status, and other relevant matters.

22. Goal/Rehabilitation Potential/Discharge Plans continued

perform allowed activities within prescribed; Cardiovascular status will improve evidenced by adequate Systolic/Diastolic BP control within 120-150/60-90mmHg 7-8 weeks respectively; Circulatory status will improve evidenced of any progression or deterioration of Coronary Atherosclerosis with current medication; GI status will improve with absence of signs/symptoms referable to Esophageal Reflux including heartburns; GU status will improve evidenced by absence of signs/symptoms referable to BPH including hesitancy, dribbling, urinary retention/obstruction; Patient will experience no s/s referable to progression or deterioration of Hyperlipidemia; Patient will take all medications as ordered without untoward effects or drug interaction; Patient/caregiver will verbalize or demonstrate understanding and compliance with teachings. Throughout certification period, Patient will remain safe at home free from injury due to fall or other causes.

REHAB POT: Fair for Patient to achieve partial return to a previous higher level of function.

DC PLAN: To self-care at home with caregiver assist/MD follow up when skilled services no longer needed.

9. Signature of Physician

(Signature applies to all Pages)

10. Date

11. Optional Name/Signature of Nurse/Therapist

12. Date

ADDENDUM TO:		<input checked="" type="checkbox"/> PLAN OF TREATMENT	<input type="checkbox"/> MEDICAL UPDATE
1. Patient's HI Claim No. 606169813M	2. Start Of Care Date 10/11/2019	3. Certification Period 10/11/2019 - 12/09/2019	4. Medical Record No. 000000202-001
5. Provider No. 053186			
6. Patient's Name and Address TOPCHYAN, OGANES 15046 GAULT ST Van Nuys, CA 91405, 818-926-1620		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117	
		818-485-235 F:818-937-090	

99. Item 99

HOMEBOUND REASON: Considerable and taxing effort to leave home even with assistance of caregiver, required assistance to ambulate, confused, unable to go out of home alone, unable to safely leave home unassisted, SOB upon moderate exertion, dependent upon adaptive devices

NEUROLOGICAL: Forgetful, otherwise alert and oriented, confused/anxious at times. Height: 69 inches, Weight: 202 lbs

CARDIOVASCULAR: Unstable/elevated BP level
RESPIRATORY: SOB with moderate exertion

RESPIRATORY: SOB with rales. Frequent coughing.

GI: Frequent heartburn
GU: Occasional stress incontinence

GU: Occasional stress incontinence
ENDOCRINE/METABOLIC: None

MUSCULOSKELETAL: Aching intermittent pain in neck, lower back, both knees, intensity 5-6/10,

relieved by rest/relaxation, rep

SKIN/INTEGUMENTARY: Turgor: good

ENT: Partially impaired vision, HOH on both ears
MOUTH: No Problem
SELF CARE: Due to forgetfulness, patient non-compliant with prescribed medications, dependent on others in all activities of daily living and medical regimen

SAFETY CONCERNS/ FUNCTIONAL LIMITATIONS: Limited in ADLs, mobility, ambulation/transfers

RISK FOR HOSPITALIZATION

RISK FOR HOSPITALIZATION:
---- Reported/observed history of difficulty complying with any medical instructions in the past 3 months

Action: Pt/PCG education, medication reconciliation every SN visits. Educate patient/pcg on medication regimen/adverse reactions to report to MD, diet, exercise regimen per MD order

-----Currently taking 5 or more medications
Action: Teach actions and side effects; teach disease process and s/s of exacerbations of chronic illness; assess pt's ability, knowledge, resources. Educate patient on medication compliance/regimen and use of medical ID bracelet.

Action: PT eval; medications evaluation, pt/agg education on emergency preparedness.

AGENCY MAY CARRY OUT ORDERS COMING DIRECTLY FROM OTHER MEDICAL PRACTITIONERS (MD, DO, DPM) WHICH
INCLUDES: PT EVAL, MEDICATIONS EVALUATION, PT/CG EDUCATION ON ENERGY CONSERVATION
TECHNIQUES/RELAXATION TECHNIQUES.

YES, but inform me NO, please course all orders through me. Thank you.

- educate on fall prevention strategies specific to areas of risk

9. Signature of Physician

(Signature applies to all Boxes)

18. Part

11. Optional Name/Signature of Nurse/Therapist

187

Doctor's Order : 10/08/19
ADMISSION

Patient Name (Code) YANKOVSKIY, NICK (223) 737 S. GENESEE AVE. APT 113	Caregiver Name (Code) STEPANYAN, MARIA (5)	Physician Name (Code) FORTALEZA, PAUL (2) 6350 LAUREL CANYON BLVD SUITE 205 North Hollywood, CA 91606
Los Angeles, CA 90036		Phone: (818) 325-2090
Phone: (818) 940-7052		Fax: (818) 325-2092
DOB: 05/19/1949		
Certification Period:	10/08/19 - 12/06/19	

Notes:

RN reports that patient was admitted to Next-Door Home Care, Inc. for skilled nursing intervention. Skilled assessment and evaluation done on all body systems, VS taken and recorded. Patient was provided with teachings on the disease process, diet and medications. Patient 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.

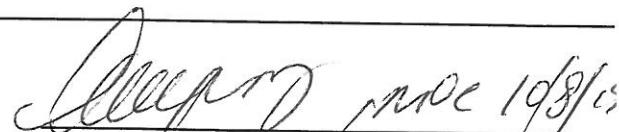
PHYSICIAN'S ORDER:

PLEASE ADMIT PATIENT FOR PERIOD OF: 10/08/19 – 12/06/19

SNV: For skilled nursing intervention and report to MD any significant change in condition, 2wk2, 1wk7

PTV: For evaluation, provide therapeutic intervention, and home safety; report to MD any significant change in condition.

ORDERS READ BACK AND CONFIRMED


Staff Signature Date 10/08/19

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. 613734510M	2. Start Of Care Date 10/08/2019	3. Certification Period 10/08/2019 - 12/06/2019	4. Medical Record No. 000000223-001	5. Provider No. 053186
6. Patient's Name and Address YANKOVSKIY, NICK 737 S. GENESEE AVE. APT 113 Los Angeles, CA 90036, 818-940-7052		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-2355 F:818-937-0901		
8. Date of Birth 05/19/1949	9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged Aspirin 81 mg 1 tab by mouth daily Buspirone 5 mg 1 tab by mouth daily Celecoxib 200 mg 1 tab by mouth daily Clobetasol propionate 0.05% cream apply topically to affected areas as needed for itching Voltaren 1% gel apply topically to affected areas as needed for pain Donepezil 23 mg 1 tab by mouth daily Please See 487		
11.ICD-10-CM M16.6	Principal Diagnosis Other bilateral secondary	Date 10/08/19	E/O	
12. ICD-10-CM	Surgical Procedure	Date		
13. ICD-10-CM M54.5 M17.4 I10. K21.9 G47.00 F03.90	Other Pertinent Diagnoses Low back pain Other bilateral secondary Essential (primary) hypertension Gastro-esophageal reflux disease Insomnia, unspecified Unspecified dementia without	Date 10/08/19 10/08/19 10/08/19 10/08/19 10/08/19 10/08/19		
14. DME and Supplies: Non-sterile gloves, incontinent supplies, cane, walker		15. Safety Measures: Fall/Bleeding/Universal Precautions, clear pathways, infection control		
16. Nutritional Req.:NAS, Low fat, Low cholesterol		17. Allergies: NKA		
18.A. Functional Limitations 1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind 2 <input checked="" type="checkbox"/> Bowel/Bladder (Incontinence) 6 <input checked="" type="checkbox"/> Endurance A <input type="checkbox"/> Dyspnea 3 <input type="checkbox"/> Contracture 7 <input checked="" type="checkbox"/> Ambulation B <input checked="" type="checkbox"/> Other (Specify) 4 <input checked="" type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech SOB w mod exert, poor vision		18.B. Activities Permitted 1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Weight Bearing A <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Independent At Home B <input checked="" type="checkbox"/> Walker 3 <input checked="" type="checkbox"/> Up As Tolerated 8 <input type="checkbox"/> Crutches C <input type="checkbox"/> No Restrictions 4 <input type="checkbox"/> Transfer Bed/Chair 9 <input checked="" type="checkbox"/> Cane D <input checked="" type="checkbox"/> Other (Specify) 5 <input checked="" type="checkbox"/> Exercises Prescribed		
19. Mental Status 1 <input checked="" type="checkbox"/> Oriented 3 <input checked="" type="checkbox"/> Forgetful 2 <input type="checkbox"/> Comatose 4 <input checked="" type="checkbox"/> Depressed		Assist with ADL's and IADL's 5 <input type="checkbox"/> Disoriented 7 <input type="checkbox"/> Agitated 6 <input type="checkbox"/> Lethargic 8 <input checked="" type="checkbox"/> Other confused, anxious at times		
20. Prognosis 1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded		3 <input checked="" type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input type="checkbox"/> Excellent		
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) PLEASE ADMIT PATIENT FOR PERIOD OF: 10/08/19 - 12/06/19				
<p>SNV: 2wk2, 1wk7 PT: Evaluation and follow up PCG NAME: Nikolay (son) PCG PHONE NUMBER: 818 5318079</p> <p>OBSERVE/ASSESS: Homebound status and medical necessity; all body systems with special emphasis on disease process, document, report significant changes in patient's condition to physician including: temperature greater than 100°F, SBP less than 90 or greater than 160, DBP less than 60 or greater than 90, or HR less than 60 or greater than 120, RR less than 14 or greater than 24; Pain over 6/10 on pain scale, and follow orders. SN to assess patient's response and compliance to medication/treatment regimen; teach/instruct/reiterate to patient/caregiver as needed regarding disease management, measures to minimize exacerbation, medication regimen, prescribed diet, fall prevention/safety measures, emergency preparedness, and all other areas of knowledge deficit as identified.</p>				
22. Goals/Rehabilitation Potential/Discharge Plans Patient's status will be monitored; abnormal findings reported to MD and identified HH care needs adequately met. During certification period; Prompt/adequate pain relief will be achieved and maintained within 0-2 (0-10 scale) through pharmacologic or non-pharmacologic measures resulting to increase in mobility, endurance, strength and ability in 4-5 weeks to				
23. Nurse's Signature and Date of Verbal SOC Where Applicable: <i>Kathy J. Mc</i>		25. Date HHA Received Signed POT 10/8/2019		
24. Physician's Name and Address FORTALEZA, PAUL 6350 LAUREL CANYON BLVD NPI: 1336368190 SUITE 205 North Hollywood, CA 91606 818-325-2090 Fax: (818) 325-2092		26. I certify <input checked="" type="checkbox"/> 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:

 PLAN OF TREATMENT MEDICAL UPDATE

1. Patient's HI Claim No. 613734510M	2. Start Of Care Date 10/08/2019	3. Certification Period 10/08/2019 - 12/06/2019	4. Medical Record No. 000000223-001	5. Provider No. 053186
6. Patient's Name and Address YANKOVSKIY, NICK 737 S. GENESEE AVE. APT 113 Los Angeles, CA 90036, 818-940-7052		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117		818-485-235 F:818-937-090

10. Medications continued

Ezetimibe 10 mg 1 tab by mouth daily
 Fluocinonide 0.05% apply topically to affected areas as needed for pain
 Hydrocortisone 2.5 % apply topically to affected areas as needed for itching
 Losartan 50 mg 1 tab by mouth daily
 Mirabegron 25 mg 1 tab by mouth daily
 Omega-3 1.000 mg 1 cap by mouth 4 times daily
 Omeprazole 40 mg 1 cap by mouth daily
 Rosuvastatin 10 mg 1 tab by mouth daily
 Temazepam 15 mg 1 tab by mouth daily at bedtime as needed for insomnia
 Vortioxetine HBr 10mg 1 tab by mouth daily

13. Other Pertinent Diagnoses continued

N32.81	Overactive bladder	10/08/2019
F32.9	Major depressive disorder, sin	10/08/2019

15. Safety Measures continued

measures, Emergency/911 protocols, patient uses cane, walker

21. Orders for Discipline and Treatments continued

INSTRUCT PATIENT/CAREGIVER: Disease process (Other bilateral secondary osteoarthritis of hip, Low back pain, Other bilateral secondary osteoarthritis of knee, Essential (primary) hypertension, Gastro-esophageal reflux disease without esophagitis, Insomnia, unspecified, Unspecified dementia without behavioral disturbance, Overactive bladder; Major depressive disorder, single episode, unspecified); medications (new or changed) as to dosage, route, frequency and adverse effects; diet regimen; pain management; energy conservation measures; coping mechanisms as necessary; home health issues (services, personnel, Patient's Rights, Privacy Act, grievance procedure, DHS hotline, Agency and other numbers to call); home safety (Box 15 above), importance of care plan compliance and to keep all MD appointments; signs and symptoms that need immediate medical attention and when to call MD; emergency procedures and 911 access; ROM exercises; signs and symptoms of hypo/hypertension and measures to take; proper use of DME.

PT: Evaluation and follow up and set up treatment plan for therapeutic HEP, physical measures and exercises to alleviate pain, equipment needs and training, home safety issues.

ANCILLARIES as ordered by MD. Notify Agency of significant clinical findings, negative outcomes, medication/service/treatment/personal change, caregiver status, and other relevant matters.

22. Goal/Rehabilitation Potential/Discharge Plans continued

perform allowed activities within prescribed; Cardiovascular status will improve evidenced by adequate Systolic/Diastolic BP control within 120-150/60-90mmHg 7-8 weeks respectively; GI status will improve with absence of signs/symptoms referable to Esophageal Reflux including heartburns; Patient will experience no signs/symptoms referable to progression or deterioration of Insomnia and improved sleeping pattern; Patient will experience no signs/symptoms referable to progression or deterioration of dementia; Patient will experience no signs/symptoms referable to progression or deterioration of overactive bladder; Patient will demonstrate stable mental status characterized by reduction of Depression, improved sleeping pattern, social interaction and coping; Patient will take all medications as ordered without untoward effects or drug interaction; Patient/caregiver will verbalize or demonstrate understanding and compliance with teachings. Throughout certification period, Patient will remain safe at home free from injury due to fall or other causes.

REHAB POT: Fair for Patient to achieve partial return to a previous higher level of function.

DC PLAN: To self-care at home with caregiver assist/MD follow up when skilled services no longer needed.

9. Signature of Physician

(Signature applies to all Pages)

10. Date

11. Optional Name/Signature of Nurse/Therapist

12. Date

ADDENDUM TO:		<input checked="" type="checkbox"/> PLAN OF TREATMENT	<input type="checkbox"/> MEDICAL UPDATE
1. Patient's HI Claim No. 613734510M	2. Start Of Care Date 10/08/2019	3. Certification Period 10/08/2019 - 12/06/2019	4. Medical Record No. 00000223-001
6. Patient's Name and Address YANKOVSKIY, NICK 737 S. GENESEE AVE. APT 113 Los Angeles, CA 90036, 818-940-7052		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117	
		818-485-235 F: 818-937-090	

99. Item 99

HOMEBOUND REASON: Considerable and taxing effort to leave home even with assistance of caregiver, required assistance to ambulate, confused, unable to go out of home alone, unable to safely leave home unassisted, SOB upon moderate exertion, dependent upon adaptive devices

NEUROLOGICAL: Forgetful, otherwise alert and oriented, confused/anxious at times. Height: 71 inches, Weight: 200 lbs.

CARDIOVASCULAR: Unstable/elevated BP le

RESPIRATORY: SOB with moderate

GI: No complaints at this time

GU: Occasional stress incontinence

ENDOCRINE/METABOLIC: No complaints at this time

MUSCULOSKELETAL: Aching intermittent

by rest/relaxation, repositioning, medications

SKIN/INTEGUMENTARY: Turgor: good

EENT: Partially impaired vision, HOH on both ears

MOUTH: No Problem

SELF CARE: Due to forgetfulness, patient non-compliant with prescribed medications, dependent on others in all activities of daily living and medical regimen management

SAFETY CONCERNs/ FUNCTIONAL LIMITATIONS: Limited in ADLs, mobility, ambulation/transfers

РЕДИ ГОР НАСВЕЧЕНІЯ ПІДПОЛІМ

RISK FOR HOSPITALIZATION:
---- Reported/observed history of difficulty complying with any medical instructions in the past 3

Action: Pt/PCG education, medication reconciliation every SN visits. Educate patient/pcg on medication regimen/adverse reactions to report to MD, diet, exercise regimen per MD order

-----Currently taking 5 or more medications
Action: Teach actions and side effects; teach disease process and s/s of exacerbations of chronic illness; assess pt's ability, knowledge, resources. Educate patient on medication compliance/monitor and use of lipid-lowering drugs.

compliance/regimen and use of medications.

Action: PT eval; medications evaluation, pt/cg education on energy conservation

TECHNIQUES/RELAXATION TECHNIQUES.
AGENCY MAY CARRY OUT ORDERS COMING DIRECTLY FROM OTHER MEDICAL PRACTITIONERS (MD, DO, DPM) WHILE
EMPLOYED IN THIS CAPACITY.

INVOLVED IN THE CARE OF THE PATIENT----(PLEASE CHECK ONE).
 YES, but inform me NO, please course all orders through me. Thank you.

FALL RISK: MEDIUM (8)

- FALL RISK: MEDIUM (8)**

 - educate on fall prevention strategies specific to areas of risk
 - monitor areas of risk to reduce fall risk

9. Signature of Physician

(Signature applies to all Pages)

10 Date

11. Optional Name/Signature of Nurse/Therapist

13 Date

Doctor's Order : 10/16/19

ADMISSION

Patient Name (Code)

PILIPSYAN, MANUK (220)
15435 VANOWEN ST #204

Van Nuys, CA 91406

Phone: (818) 357-1265

DOB: 09/30/1954

Certification Period: 10/16/19 - 12/14/19

Caregiver Name (Code)

AKOPYAN, AIDA (61)

Physician Name (Code)

FORTALEZA, PAUL (2)
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 Next-Door Home Care, Inc. for skilled nursing intervention. Skilled assessment and evaluation done on all body systems, VS taken and recorded. Patient was provided with teachings on the disease process, diet and medications. Patient 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.

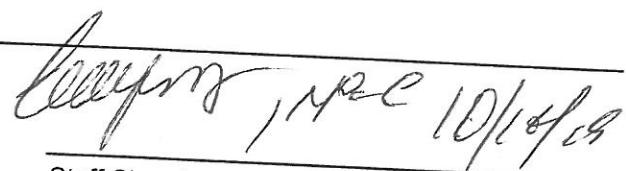
PHYSICIAN'S ORDER:

PLEASE ADMIT PATIENT FOR PERIOD OF: 10/16/19- 12/14/19

SNV: For skilled nursing intervention and report to MD any significant change in condition, 2wk2, 1wk7

PTV: For evaluation, provide therapeutic intervention, and home safety; report to MD any significant change in condition.

ORDERS READ BACK AND CONFIRMED



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. 8J60Q24KE90	2. Start Of Care Date 10/16/2019	3. Certification Period 10/16/2019 - 12/14/2019	4. Medical Record No. 000000220-001
6. Patient's Name and Address PILIPSYAN, MANUK 15435 VANOWEN ST #204 Van Nuys, CA 91406, 818-357-1265		5. Provider No. 053186	

8. Date of Birth	09/30/1954	9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117		
11. ICD-10-CM M17.4	Principal Diagnosis Other bilateral secondary	Date 10/16/09			
12. ICD-10-CM	Surgical Procedure	Date		10. Medications: Dose/Frequency/Route (N)ew (C)hanged Alprazolam 1 mg one tab by mouth once daily as needed for anxiety Tamsulosin HCL 0.4 mg one tab by mouth once daily Clopidogrel 75 mg one tab by mouth once daily Mirtazapine 30 mg one tab by mouth once Please See 487	
13. ICD-10-CM M16.11 R26.81 I11.9 I25.810 F32.9 E78.5	Other Pertinent Diagnoses Unilateral primary osteoart Unsteadiness on feet Hypertensive heart disease Atherosclerosis of CABG w/o Major depressive disorder, Hyperlipidemia, unspecified	Date 10/16/09 10/16/09 10/16/09 10/16/09 10/16/09 10/16/09		14. DME and Supplies: Non-sterile gloves, incontinent supplies, cane	
16. Nutritional Req.: NAS, Low fat, Low cholesterol				15. Safety Measures: Fall/Bleeding/Universal Precautions, clear pathways, infection control	
18.A Functional Limitations		18.B Activities Permitted		17. Allergies: Sun	
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	A <input type="checkbox"/> Wheelchair
2 <input checked="" type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input checked="" type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea	2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent At Home	B <input checked="" type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input checked="" type="checkbox"/> Ambulation	B <input checked="" type="checkbox"/> Other (Specify) SOB w mod exert, poor vision	3 <input checked="" type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	C <input type="checkbox"/> No Restrictions
4 <input checked="" type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		4 <input type="checkbox"/> Transfer Bed/Chair	9 <input checked="" type="checkbox"/> Cane	D <input checked="" type="checkbox"/> Other (Specify)
Assist with ADL's and IADL's					
19. Mental Status	1 <input checked="" type="checkbox"/> Oriented	3 <input checked="" type="checkbox"/> Forgetful	5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated	
20. Prognosis	2 <input type="checkbox"/> Comatose	4 <input checked="" type="checkbox"/> Depressed	6 <input type="checkbox"/> Lethargic	8 <input checked="" type="checkbox"/> Other	confused, anxious at times
5 <input type="checkbox"/> Excellent					
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) PLEASE ADMIT PATIENT FOR PERIOD OF: 10/16/19 - 12/14/19					

SNV: 2wk2, 1wk7

PT: Evaluation and follow up
PCG NAME: Ovsanna (daughter)

PCG PHONE NUMBER: 323 5284111

OBSERVE/ASSESS: Homebound status and medical necessity; all body systems with special emphasis on disease process, document, report significant changes in patient's condition to physician including: temperature greater than 100°F, SBP less than 90 or greater than 160, DBP less than 60 or greater than 90, or HR less than 60 or greater than 120, RR less than 14 or greater than 24; Pain over 6/10 on pain scale, and follow orders. SN to assess patient's response and compliance to medication/treatment regimen; teach/instruct/reiterate to patient/caregiver as needed regarding disease management, measures to minimize exacerbation, medication regimen, prescribed diet, fall prevention/safety measures, emergency preparedness, and all other areas of knowledge deficit as identified.

22. Goals/Rehabilitation Potential/Discharge Plans Patient's status will be monitored; abnormal findings reported to MD and identified HH care needs adequately met. During certification period; Prompt/adequate pain relief will be achieved and maintained within 0-2 (0-10 scale) through pharmacologic or non-pharmacologic measures resulting to increase in mobility, endurance, strength and ability in 4-7 weeks to		25. Date HHA Received Signed POT 10/16/2019
24. Physician's Name and Address FORTALEZA, PAUL 6350 LAUREL CANYON BLVD SUITE 205 North Hollywood, CA 91606 818-325-2090 Fax: (818) 325-2092		26. I certify <input checked="" type="checkbox"/> 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:

 PLAN OF TREATMENT MEDICAL UPDATE

1. Patient's HI Claim No. 8J60Q24KE90	2. Start Of Care Date 10/16/2019	3. Certification Period 10/16/2019 - 12/14/2019	4. Medical Record No. 000000220-001	5. Provider No. 053186
6. Patient's Name and Address PILIPOSYAN, MANUK 15435 VANOWEN ST #204 Van Nuys, CA 91406, 818-357-1265		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-235 F:818-937-090		

10. Medications continued

daily
 Losartan/HCTZ 100-25 mg one tab by mouth once daily every morning
 Aspirin 81 mg one tab by mouth once daily
 Atorvastatin 40 mg one tab by mouth once daily
 Sertraline 50 mg one tab by mouth once daily
 Clonidine 0.1 mg one tab by mouth once daily as needed if SBP is more than 160 mmHg
 Tylenol ES 500 mg one tab by mouth every 8 hrs as needed for moderate to severe pain
 Diclofenac Sodium 1% topical gel apply to affected areas 2 times daily as needed for moderate pain

13. Other Pertinent Diagnoses continued

n40.0 Benign prostatic hyperplasia w

10/16/2009

15. Safety Measures continued

measures, Emergency/911 protocols, patient uses cane

21. Orders for Discipline and Treatments continued

INSTRUCT PATIENT/CAREGIVER: Disease process (Other bilateral secondary osteoarthritis of knee, Unilateral primary osteoarthritis, right hip, Unsteadiness on feet, Hypertensive heart disease without heart failure, Atherosclerosis of CABG w/o angina pectoris, Major depressive disorder, single episode, unspecified, Hyperlipidemia, unspecified, Benign prostatic hyperplasia without lower urinary tract symp,); medications (new or changed) as to dosage, route, frequency and adverse effects; diet regimen; pain management; energy conservation measures; coping mechanisms as necessary; home health issues (services, personnel, Patient's Rights, Privacy Act, grievance procedure, DHS hotline, Agency and other numbers to call); home safety (Box 15 above), importance of care plan compliance and to keep all MD appointments; signs and symptoms that need immediate medical attention and when to call MD; emergency procedures and 911 access; ROM exercises; signs and symptoms of hypo/hypertension and measures to take; proper use of DME.

PT: Evaluation and follow up and set up treatment plan for therapeutic HEP, physical measures and exercises to alleviate pain, equipment needs and training, home safety issues.

ANCILLARIES as ordered by MD. Notify Agency of significant clinical findings, negative outcomes, medication/service/treatment/personal change, caregiver status, and other relevant matters.

22. Goal/Rehabilitation Potential/Discharge Plans continued

perform allowed activities within prescribed; Patient will not experience any falls or injury related to unsteady gait during certification period; Cardiovascular status will improve evidenced by adequate Systolic/Diastolic BP control within 120-150/60-90mmHg 7-8 weeks respectively; Circulatory status will improve evidenced of any progression or deterioration of Coronary Atherosclerosis with current medication; Patient will demonstrate stable mental status characterized by reduction of Depression, improved sleeping pattern, social interaction and coping; Patient will experience no s/s referable to progression or deterioration of Hyperlipidemia; GU status will improve evidenced by absence of signs/symptoms referable to BPH including hesitancy, dribbling, urinary retention/obstruction; Patient will take all medications as ordered without untoward effects or drug interaction; Patient/caregiver will verbalize or demonstrate understanding and compliance with teachings. Throughout certification period, Patient will remain safe at home free from injury due to fall or other causes.

REHAB POT: Fair for Patient to achieve partial return to a previous higher level of function.

DC PLAN: To self-care at home with caregiver assist/MD follow up when skilled services no longer

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

9. Signature of Physician

(Signature applies to all Pages)

10. Date

11. Optional Name/Signature of Nurse/Therapist

12. Date

Doctor's Order : 10/12/19

ADMISSION

Patient Name (Code)ETINDJIKIAN, VOSKAN (210)
7648 Wilkinson Ave**Caregiver Name (Code)**

AKOPYAN, AIDA (61)

Physician Name (Code)FORTALEZA, PAUL (2)
6350 LAUREL CANYON BLVD
SUITE 205
North Hollywood, CA 91606
Phone: (818) 325-2090
Fax: (818) 325-2092

North Hollywood, CA 91605

Phone: (818) 621-9455

DOB: 07/02/1953

Certification Period: 10/12/19 - 12/10/19

Notes:

RN reports that patient was admitted to Next-Door Home Care, Inc. for skilled nursing intervention. Skilled assessment and evaluation done on all body systems, VS taken and recorded. Patient was provided with teachings on the disease process, diet and medications. Patient 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.

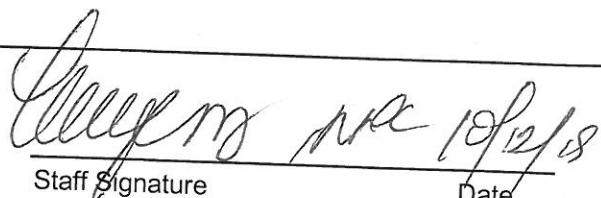
PHYSICIAN'S ORDER:

PLEASE ADMIT PATIENT FOR PERIOD OF: 10/12/19 – 12/10/19

SNV: For skilled nursing intervention and report to MD any significant change in condition, 1wk1, 2wk2, 1wk6

PTV: For evaluation, provide therapeutic intervention, and home safety; report to MD any significant change in condition.

ORDERS READ BACK AND CONFIRMED


Signature over a horizontal line

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. 7FF0V03DX21	2. Start Of Care Date 10/12/2019	3. Certification Period 10/12/2019 - 12/10/2019	4. Medical Record No. 000000210-001	5. Provider No. 053186
6. Patient's Name and Address ETINDJIKIAN, VOSKAN 7648 Wilkinson Ave North Hollywood, CA 91605, 818-621-9455		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-2350 F: 818-937-0900		
8. Date of Birth 07/02/1953	9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged Atorvastatin Calcium 20 mg one tab by mouth once daily Hydralazine HCL 10 mg one tab by mouth twice daily for allergies Triamcinolone 1% cream apply topically to affected areas twice daily Please See 487		
11.ICD-10-CM M16.0	Principal Diagnosis Bilateral primary osteoarthritis	Date 10/12/19	E/O	
12. ICD-10-CM	Surgical Procedure	Date		
13. ICD-10-CM M17.0	Other Pertinent Diagnoses Bilateral primary osteoarthritis	Date 10/12/19		
M54.5	Low back pain	10/12/19		
M62.81	Muscle weakness (generalized)	10/12/19		
R26.81	Unsteadiness on feet	10/12/19		
K21.9	Gastro-esophageal reflux disease	10/12/19		
E78.5	Hyperlipidemia, unspecified	10/12/19		
14. DME and Supplies: Non-sterile gloves, incontinent supplies, cane		15. Safety Measures: Fall/Bleeding/Universal Precautions, clear pathways, infection control		
16. Nutritional Req:NAS, Low fat, Low cholesterol		17. Allergies: Seasonal		
18.A Functional Limitations		18.B Activities Permitted		
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	1 <input type="checkbox"/> Complete Bedrest	A <input type="checkbox"/> Wheelchair
2 <input checked="" type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input checked="" type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea	2 <input type="checkbox"/> Bedrest BRP	B <input type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input checked="" type="checkbox"/> Ambulation	B <input checked="" type="checkbox"/> Other (Specify)	3 <input checked="" type="checkbox"/> Up As Tolerated	C <input type="checkbox"/> No Restrictions
4 <input checked="" type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech	SOB w mod exert, poor vision	4 <input type="checkbox"/> Transfer Bed/Chair	D <input checked="" type="checkbox"/> Other (Specify)
		5 <input checked="" type="checkbox"/> Exercises Prescribed		
		Assist with ADL's and IADL's		
19. Mental Status		1 <input checked="" type="checkbox"/> Oriented	3 <input checked="" type="checkbox"/> Forgetful	5 <input type="checkbox"/> Disoriented
		2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed	6 <input type="checkbox"/> Lethargic
20. Prognosis		1 <input type="checkbox"/> Poor	2 <input type="checkbox"/> Guarded	3 <input checked="" type="checkbox"/> Fair
		4 <input type="checkbox"/> Good		5 <input type="checkbox"/> Excellent
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) PLEASE ADMIT PATIENT FOR PERIOD OF: 10/12/19 - 12/10/19				
SNV: 1wk1, 2wk2, 1wk6 PT: Evaluation and follow up PCG NAME: Roza (wife) PCG PHONE NUMBER: 818 6219455				
OBSERVE/ASSESS: Homebound status and medical necessity; all body systems with special emphasis on disease process, document, report significant changes in patient's condition to physician including: temperature greater than 100°F, SBP less than 90 or greater than 160, DBP less than 60 or greater than 90, or HR less than 60 or greater than 120, RR less than 14 or greater than 24; Pain over 6/10 on pain scale, and follow orders. SN to assess patient's response and compliance to medication/treatment regimen; teach/instruct/reiterate to patient/caregiver as needed regarding disease management, measures to minimize exacerbation, medication regimen, prescribed diet, fall prevention/safety measures, emergency preparedness, and all other areas of knowledge deficit as identified.				
22. Goals/Rehabilitation Potential/Discharge Plans Patient's status will be monitored; abnormal findings reported to MD and identified HH care needs adequately met. During certification period; Prompt/adequate pain relief will be achieved and maintained within 0-2 (0-10 scale) through pharmacologic or non-pharmacologic measures resulting to increase in mobility, endurance, strength and ability in 4-5 weeks to				
23. Nurse's Signature and Date of Verbal SOC Where Applicable: <i>Cheryn Moe</i>		25. Date HHA Received Signed POT 10/12/2019		
24. Physician's Name and Address FORTALEZA, PAUL 6350 LAUREL CANYON BLVD SUITE 205 North Hollywood, CA 91606 818-325-2090 Fax: (818) 325-2092		26. I certify <input checked="" type="checkbox"/> 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:

 PLAN OF TREATMENT MEDICAL UPDATE

1. Patient's HI Claim No. 7FF0V03DX21	2. Start Of Care Date 10/12/2019	3. Certification Period 10/12/2019 -12/10/2019	4. Medical Record No. 000000210-001	5. Provider No. 053186
6. Patient's Name and Address ETINDJIKIAN, VOSKAN 7648 Wilkinson Ave North Hollywood, CA 91605, 818-621-9455		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-235 F:818-937-090		

10. Medications continued
- Loratadine 10 mg one tab by mouth once daily
 Diclofenac 1%Transdermal Gel apply topically to affected areas 4 times daily as needed for moderate to severe pain
 Aspirin 81 mg one tab by mouth once daily
 Omeprazole 20 mg one tab by mouth once daily
 Fluticasone Propionate HFA 110 mcg/ACT inhalation aerosol one spray into both nostrils once daily
 Epinephrine 0.3 mg inject subcutaneously one syringe as needed for anaphylaxis
15. Safety Measures continued
- measures, Emergency/911 protocols, patient uses cane
21. Orders for Discipline and Treatments continued
- INSTRUCT PATIENT/CAREGIVER: Disease process (Bilateral primary osteoarthritis of hip, Bilateral primary osteoarthritis of knee, Low back pain, Muscle weakness (generalized), Unsteadiness on feet, Gastro-esophageal reflux disease without esophagitis, Hyperlipidemia, unspecified); medications (new or changed) as to dosage, route, frequency and adverse effects; diet regimen; pain management; energy conservation measures; coping mechanisms as necessary; home health issues (services, personnel, Patient's Rights, Privacy Act, grievance procedure, DHS hotline, Agency and other numbers to call); home safety (Box 15 above), importance of care plan compliance and to keep all MD appointments; signs and symptoms that need immediate medical attention and when to call MD; emergency procedures and 911 access; ROM exercises; signs and symptoms of hypo/hypertension and measures to take; proper use of DME.
- PT: Evaluation and follow up and set up treatment plan for therapeutic HEP, physical measures and exercises to alleviate pain, equipment needs and training, home safety issues.
- ANCILLARIES as ordered by MD. Notify Agency of significant clinical findings, negative outcomes, medication/service/treatment/personal change, caregiver status, and other relevant matters.
22. Goal/Rehabilitation Potential/Discharge Plans continued
- perform allowed activities within prescribed; Patient will remain free from signs/symptoms of muscle weakness with current medication thought-out certification period; Patient will not experience any falls or injury related to unsteady gait during certification period; GI status will improve with absence of signs/symptoms referable to Esophageal Reflux including heartburns; Patient will experience no s/s referable to progression or deterioration of Hyperlipidemia; Patient will take all medications as ordered without untoward effects or drug interaction; Patient/caregiver will verbalize or demonstrate understanding and compliance with teachings. Throughout certification period, Patient will remain safe at home free from injury due to fall or other causes.
- REHAB POT: Fair for Patient to achieve partial return to a previous higher level of function.
- DC PLAN: To self-care at home with caregiver assist/MD follow up when skilled services no longer needed.
99. Item 99
- HOMEBOUND REASON: Considerable and taxing effort to leave home even with assistance of caregiver, required assistance to ambulate, confused, unable to go out of home alone, unable to safely leave home unassisted, SOB upon moderate exertion, dependent upon adaptive devices
 NEUROLOGICAL: Forgetful, otherwise alert and oriented, confused/anxious at times. Height: 65 inches, Weight: 165 lbs
 CARDIOVASCULAR: Unstable/elevated BP level, No Edema

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

ADDENDUM TO:		<input checked="" type="checkbox"/> PLAN OF TREATMENT	<input type="checkbox"/> MEDICAL UPDATE
1. Patient's HI Claim No. 7FF0V03DX21	2. Start Of Care Date 10/12/2019	3. Certification Period 10/12/2019 - 12/10/2019	4. Medical Record No. 00000210-001
6. Patient's Name and Address ETINDJIKIAN, VOSKAN 7648 Wilkinson Ave North Hollywood, CA 91605, 818-621-9455		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117	
		818-485-23 F:818-937-09	

RESPIRATORY: SOB with moderate exertion

GI: Frequent heartburn

GU: Occasional stress inc.

ENDOCRINE/METABOLIC: No complaints.

MUSCULOSKELETAL: Aching intermittent pain lower

NEUROLOGIC: Aching intermittent pain lower back, both hips, both knees, intensity 5-6/10, relieved by rest/relaxation, repositioning, medications

SKIN/INTEGUMENTARY: Turgor: good

EENT: Partially impaired vision
MOUTH: No unusual

MOUTH: No problem

SELF CARE: Due to forgetfulness, patient non-compliant with prescribed medications, dependent on others in all activities of daily living and medical regimen management.

LIMITATIONS: Limited in ADLs, mobility, ambulation/transfers, self-care, living and medical regimen management

PSYCHOSOCIAL STATUS: Lives with other family member with regular daytime assistance.

RISK FOR HOSPITALIZATION:

----- Reported/observed history of difficulty complying with any medical instructions in the past 3 months

Action: Pt/PCG education, medication reconciliation every SN visits. Educate patient/pcg on medication regimen/adverse reactions to report to MD, diet, exercise regimen per MD order
---Currently taking 5 or more medications

-----Currently taking 5 or more medications
Action: Teach actions and side effects; teach disease process and s/s of exacerbations of chronic illness; assess pt's ability, knowledge, resources. Educate patient on medication compliance/regimen and use of medical ID bracelet.

compliance/regimen and use of me
----Currently reports exhaustion

Action: PT eval; medications evaluation, pt/cg education on energy conservation techniques/relaxation techniques

AGENCY MAY CARRY OUT ORDERS COMING DIRECTLY FROM OTHER MEDICAL PRACTITIONERS (MD, DO, DPM) WHOLE
INVOLVED IN THE CARE OF THE PATIENT.

INVOLVED IN THE CARE OF THE PATIENT-----
 (X) YES, but inform me

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- educate on fall prevention strategies specific to areas of risk

9. Signature of Physician

(Signature applies to all Pages)

10 Date

11. Optional Name/Signature of Nurse/Therapist

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HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No. 609164640M	2. Start Of Care Date 10/06/2019	3. Certification Period 10/06/2019 - 12/04/2019	4. Medical Record No. 000000192-001	5. Provider No. 053186
6. Patient's Name and Address MURADYAN, SVETLANA 6237 FARMDALE AVE North Hollywood, CA 91606, 818-261-6616		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-235 F: 818-937-090		
8. Date of Birth 06/14/1940	9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged Alendronate 70mg one tab by mouth once a week Docusate 100 mg one tab by mouth once daily Vitamin B12 one tab by mouth once daily Bisacodyl 5 mg one tab by mouth twice daily Calcium Carbo. 600 mg one tab by mouth twice daily Please See 487		
11. ICD-10-CM M17.0	Principal Diagnosis Bilateral primary osteoarthritis	Date 10/06/19	E/O	
12. ICD-10-CM	Surgical Procedure	Date		
13. ICD-10-CM M16.0	Other Pertinent Diagnoses Bilateral primary osteoarthritis	Date 10/06/19		
M54.5	Low back pain	10/06/19		
I11.9	Hypertensive heart disease	10/06/19		
G30.9	Alzheimer's disease, unspecified	10/06/19		
F32.9	Major depressive disorder, mild	10/06/19		
M81.0	Age-related osteoporosis with fractures	10/06/19		
14. DME and Supplies: Non-sterile gloves, incontinent supplies, cane, walker		15. Safety Measures: Fall/Bleeding/Universal Precautions, clear pathways, infection control		
16. Nutritional Req.NAS		17. Allergies: NKA		
18.A Functional Limitations		18.B Activities Permitted		
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	1 <input type="checkbox"/> Complete Bedrest	A <input type="checkbox"/> Wheelchair
2 <input checked="" type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input checked="" type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea	2 <input type="checkbox"/> Bedrest BRP	B <input checked="" type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input checked="" type="checkbox"/> Ambulation	B <input checked="" type="checkbox"/> Other (Specify)	3 <input checked="" type="checkbox"/> Up As Tolerated	C <input type="checkbox"/> No Restrictions
4 <input checked="" type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech	SOB w mod exert, poor vision	4 <input type="checkbox"/> Transfer Bed/Chair	D <input checked="" type="checkbox"/> Other (Specify)
5 <input checked="" type="checkbox"/> Exercises Prescribed				Assist with ADL's and IADL's
19. Mental Status	1 <input checked="" type="checkbox"/> Oriented	3 <input checked="" type="checkbox"/> Forgetful	5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated
	2 <input type="checkbox"/> Comatose	4 <input checked="" type="checkbox"/> Depressed	6 <input type="checkbox"/> Lethargic	8 <input checked="" type="checkbox"/> Other confused, anxious at times
20. Prognosis	1 <input type="checkbox"/> Poor	2 <input type="checkbox"/> Guarded	3 <input checked="" type="checkbox"/> Fair	4 <input type="checkbox"/> Good
				5 <input type="checkbox"/> Excellent
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) PLEASE ADMIT PATIENT FOR PERIOD OF: 10/06/19 - 12/04/19				
SNV: 3wk1, 2wk2, 1wk6 PT: Evaluation and follow up PCG NAME: Ara (son) PCG PHONE NUMBER: 8182616616				
OBSERVE/ASSESS: Homebound status and medical necessity; all body systems with special emphasis on disease process, document, report significant changes in patient's condition to physician including: temperature greater than 100°F, SBP less than 90 or greater than 160, DBP less than 60 or greater than 90, or HR less than 60 or greater than 120, RR less than 14 or greater than 24; Pain over 6/10 on pain scale, and follow orders. SN to assess patient's response and compliance to medication/treatment regimen; teach/instruct/reiterate to patient/caregiver as needed regarding disease management, measures to minimize exacerbation, medication regimen, prescribed diet, fall prevention/safety measures, emergency preparedness, and all other areas of knowledge deficit as identified.				
22. Goals/Rehabilitation Potential/Discharge Plans Patient's status will be monitored; abnormal findings reported to MD and identified HH care needs adequately met. During certification period; Prompt/adequate pain relief will be achieved and maintained within 0-2 (0-10 scale) through pharmacologic or non-pharmacologic measures resulting to increase in mobility, endurance, strength and ability in 4-6 weeks to				
23. Nurse's Signature and Date of Verbal SOC Where Applicable: <i>[Signature]</i>		25. Date HHA Received Signed POT 10/6/2019		
24. Physician's Name and Address FORTALEZA, PAUL 6350 LAUREL CANYON BLVD SUITE 205 North Hollywood, CA 91606 818-325-2090 Fax: (818) 325-2092		26. I certify <input checked="" type="checkbox"/> 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:		<input checked="" type="checkbox"/> PLAN OF TREATMENT		<input type="checkbox"/> MEDICAL UPDATE
1. Patient's HI Claim No. 609164640M	2. Start Of Care Date 10/06/2019	3. Certification Period 10/06/2019 - 12/04/2019	4. Medical Record No. 000000192-001	5. Provider No. 053186
6. Patient's Name and Address MURADYAN, SVETLANA 6237 FARMDALE AVE North Hollywood, CA 91606, 818-261-6616		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117		
			818-485-235 F:818-937-090	

10. Medications continued
- Donepezil 5 mg one tab by mouth twice daily
 Memantine 10 mg one tab by mouth twice daily
 Aspirin 81 mg one tab by mouth once daily
 Tamsulosin HCL 0.4 mg one tab by mouth once daily
 Atenolol 50 mg one tab by mouth twice daily
 Amlodipine 5 mg one tab by mouth once daily
 Losartan /HCTZ 100-25 mg one tab by mouth once daily
 Vitamin D3 2000 international units one tab by mouth once daily
 Escitalopram 10 mg one tab by mouth once daily
 Advil 200 mg 2 tabs by mouth every 6 hrs as needed for moderate to severe pain
13. Other Pertinent Diagnoses continued
- R33.9 Retention of urine, unspecific 10/06/2019
15. Safety Measures continued
- measures, Emergency/911 protocols, patient uses cane, walker
21. Orders for Discipline and Treatments continued
- INSTRUCT PATIENT/CAREGIVER: Disease process (Bilateral primary osteoarthritis of knee, Bilateral primary osteoarthritis of hip, Low back pain, Hypertensive heart disease without heart failure, Alzheimer's disease, unspecified, Major depressive disorder, single episode, unspecified, Age-related osteoporosis w/o current pathological fracture, Retention of urine, unspecified); medications (new or changed) as to dosage, route, frequency and adverse effects; diet regimen; pain management; energy conservation measures; coping mechanisms as necessary; home health issues (services, personnel, Patient's Rights, Privacy Act, grievance procedure, DHS hotline, Agency and other numbers to call); home safety (Box 15 above), importance of care plan compliance and to keep all MD appointments; signs and symptoms that need immediate medical attention and when to call MD; emergency procedures and 911 access; ROM exercises; signs and symptoms of hypo/hypertension and measures to take; proper use of DME.
- PT: Evaluation and follow up and set up treatment plan for therapeutic HEP, physical measures and exercises to alleviate pain, equipment needs and training, home safety issues.
- ANCILLARIES as ordered by MD. Notify Agency of significant clinical findings, negative outcomes, medication/service/treatment/personal change, caregiver status, and other relevant matters.
22. Goal/Rehabilitation Potential/Discharge Plans continued
- perform allowed activities within prescribed; Cardiovascular status will improve evidenced by adequate Systolic/Diastolic BP control within 120-150/60-90mmHg 7-8 weeks respectively; Patient will experience no s/s referable to progression of Alzheimer's disease; Patient will demonstrate stable mental status characterized by reduction of Depression, improved sleeping pattern, social interaction and coping; Patient will experience no signs/symptoms referable to progression or deterioration of Osteoporosis; GU status will improve evidenced by absence of signs/symptoms referable to BPH including hesitancy, dribbling, urinary retention/obstruction; Patient will take all medications as ordered without untoward effects or drug interaction; Patient/caregiver will verbalize or demonstrate understanding and compliance with teachings. Throughout certification period, Patient will remain safe at home free from injury due to fall or other causes.
- REHAB POT: Fair for Patient to achieve partial return to a previous higher level of function.
- DC PLAN: To self-care at home with caregiver assist/MD follow up when skilled services no longer needed.

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

ADDENDUM TO:

 PLAN OF TREATMENT MEDICAL UPDATE

1. Patient's HI Claim No. 609164640M	2. Start Of Care Date 10/06/2019	3. Certification Period 10/06/2019 - 12/04/2019	4. Medical Record No. 000000192-001	5. Provider No. 053186
6. Patient's Name and Address MURADYAN, SVETLANA 6237 FARMDALE AVE North Hollywood, CA 91606, 818-261-6616		7. Provider's Name, Address, and Telephone Number Next Door Home Care, Inc. 412 W. Broadway Suite 305 Glendale, CA 91204-4117 818-485-23 F:818-937-09		

99. Item 99

HOMEBOUND REASON: Considerable and taxing effort to leave home even with assistance of caregiver, required assistance to ambulate, confused, unable to go out of home alone, unable to safely leave home unassisted, SOB upon moderate exertion, dependent upon adaptive devices

NEUROLOGICAL: Forgetful, otherwise alert and oriented, confused/anxious at times. Height: 65 inches Weight: 165 lbs

CARDIOVASCULAR: Unstable/elevated BP level, No Edema

RESPIRATORY: SOB with moderate exertion

GI: No complaints at this time

GU: Occasional stress incontinence

ENDOCRINE/METABOLIC: No complaints at this time

MUSCULOSKELETAL: Aching intermittent pain in lower back, both hips, knees, shoulders, intensity 5-6/10, relieved by rest/relaxation, repositioning, medications

SKIN/INTEGUMENTARY: Turgor: good

EENT: Partially impaired vision, HOH on both ears

MOUTH: Dentures: Upper, Lower, Partial

SELF CARE: Due to forgetfulness, patient non-compliant with prescribed medications, dependent on others in all activities of daily living and medical regimen management

SAFETY CONCERNS/ FUNCTIONAL LIMITATIONS: Limited in ADLs, mobility, ambulation/transfers

PSYCHOSOCIAL STATUS: Lives with other family member with regular daytime assistance

RISK FOR HOSPITALIZATION:

---- Reported/observed history of difficulty complying with any medical instructions in the past 3 months

Action: Pt/PCG education, medication reconciliation every SN visits. Educate patient/pcg on medication regimen/adverse reactions to report to MD, diet, exercise regimen per MD order
----Currently taking 5 or more medications

Action: Teach actions and side effects; teach disease process and s/s of exacerbations of chronic illness; assess pt's ability, knowledge, resources. Educate patient on medication compliance/regimen and use of medical ID bracelet.

----Currently reports exhaustion

Action: PT eval; medications evaluation, pt/cg education on energy conservation techniques/relaxation techniques.

AGENCY MAY CARRY OUT ORDERS COMING DIRECTLY FROM OTHER MEDICAL PRACTITIONERS (MD, DO, DPM) WHILE INVOLVED IN THE CARE OF THE PATIENT-----(PLEASE CHECK ONE).

(X) YES, but inform me

() NO, please course all orders through me. Thank you

DISCHARGE SUMMARY AVAILABLE UPON REQUEST.

FALL RISK: MEDIUM (7)

- educate on fall prevention strategies specific to areas of risk
- monitor areas of risk to reduce fall

9. Signature of Physician

(Signature applies to all Pages)

10. Date

11. Optional Name/Signature of Nurse/Therapist

12. Date

**Doctor's Order : 10/06/19
ADMISSION****Patient Name (Code)**MURADYAN, SVETLANA (192)
6237 FARMDALE AVE**Caregiver Name (Code)**

AKOPYAN, AIDA (61)

Physician Name (Code)FORTALEZA, PAUL (2)
6350 LAUREL CANYON BLVD
SUITE 205
North Hollywood, CA 91606
Phone: (818) 325-2090
Fax: (818) 325-2092

North Hollywood, CA 91606

Phone: (818) 261-6616

DOB: 06/14/1940

Certification Period: 10/06/19 - 12/04/19

Notes:

RN reports that patient was admitted to Next-Door Home Care, Inc. for skilled nursing intervention. Skilled assessment and evaluation done on all body systems, VS taken and recorded. Patient was provided with teachings on the disease process, diet and medications. Patient 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.

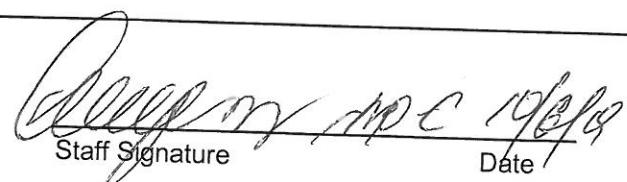
PHYSICIAN'S ORDER:

PLEASE ADMIT PATIENT FOR PERIOD OF: 10/06/19 – 12/04/19

SNV: For skilled nursing intervention and report to MD any significant change in condition, 3wk1, 2wk2, 1wk6

PTV: For evaluation, provide therapeutic intervention, and home safety; report to MD any significant change in condition.

ORDERS READ BACK AND CONFIRMED


Staff Signature DateFORTALEZA, PAUL
6350 LAUREL CANYON BLVD
SUITE 205
North Hollywood, CA 91606_____
Physician Signature_____
Date