Post Hospital Order 04/08/2016 (272263381)
Turner, Erma (3730)
Addition to CMS 485 Episode: 03/28/16 - 05/26/16
Resumption of Care Date 04/08/2016

Novel Home Healthcare Agency
7920 Beltline Road
Dallas, TX 75254 (972) 994-9395

Patient Information

Hospital Stay From: 04/01/2016 to 04/06/2016

Surgical Diagnosis a. **Date:** --/--/----
Surgical Diagnosis b. **Date:** --/--/----
Surgical Diagnosis c. **Date:** --/--/----
Surgical Diagnosis d. **Date:** --/--/----

(M1011) List each **Inpatient Diagnosis** and ICD-10-C M code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

Inpatient Facility Diagnosis	ICD-10-C M Code
a. Pneumonia, unspecified organism	J18.9
b. Hypokalemia	E87.6
c. Abnormal levels of other serum enzymes	R74.8
d. Iron deficiency anemia secondary to blood loss (chronic)	D50.0
e.	
f.	

(M1021a) Primary Diagnosis: J18.9
(M1023b) Secondary Diagnosis: I12.9

Medication: Dose, Frequency, Route, New, Changed

ofloxacin 400mg 1tab po q48hrs x 2days-pneumonia (N)
Kdipine ER Oral 60 MG 1 Tab(s) bid
sartan Oral 160 MG 1 Tab(s) daily (N)
ma-Vite Rx Oral 1 MG 1 Tab(s) daily
mvela Oral 800 MG 1 Tab(s) TID
mamir Subcutaneous 100 UNIT/ML 25 units ml Q a.m *(Continued)*

DME/Supplies

DME

Bedside Commode	☐ Cane	☐ Elevated Toilet Seat	☐ Grab Bars	☐ Hospital Bed
Nebulizer	☐ Oxygen	☐ Tub/Shower Bench	☐ Walker	☐ Wheelchair

Other:

Supplies

ABDs	☐ Ace Wrap	✓ Alcohol Pads	☐ Chux/Underpads	✓ Diabetic Supplies
Drainage Bag	☐ Dressing Supplies	☐ Duoderm	✓ Exam Gloves	☐ Foley Catheter
Gauze Pads	☐ Insertion Kit	☐ Irrigation Set	☐ Irrigation Solution	☐ Kerlix Rolls
Leg Bag	☐ Needles	☐ NG Tube	✓ Probe Covers	✓ Sharps Container
Sterile Gloves	☐ Syringe	☐ Tape		

Other:

Orders for Discipline and Treatments

to: 1w8, .
the Patient DNR (Do Not Resuscitate)? No.
Bound Status: Other - poor endurance,Requires max assistance/taxing effort to leave home,Unable to
, leave home unassisted.
by physician of: Temperature greater than (>) 101.0 or less than (<) 95.0.
ntinued)

Goals/Rehabilitation Potential/Discharge Plans

patient will have no hospitalizations during the certification period.
Pt will verbalize understanding of proper use of pain medication by 05/26/2016.
Wnd(s) will heal without complication by: 05/26/2016.
Wnd(s) will be free from signs and symptoms of infection during 60 day episode. *(Continued)*

Nursing Frequencies for Skilled and Non-Skilled Services

SN: 1w8 PT:
OT: ST:
MSW: HHA:

Signature & Title: (Ogbu, Jessy Rita)	Date
Digitally Signed by: Jessy Rita Ogbu , RN	04/08/2016

Physician's Name	Physician's Address	
Umana Kotha	2925 Skyway Circle North IRVING TX 75038- IRVING TX 75038	(972) 675-7313 **(Phone)** (972) 675-7310 **(Fax)**

S. Ketha Electronically signed by: Sumana Ketha, M.D.

Physician Signature:	Date 06/10/2016

[illegible] Therapy Frequency Route, New Changes (Continued)

[illegible]N 70/30 Subcutaneous (70-30) 100 UNIT/ML 28 units ml Q p.m
[illegible]N 70/30 Subcutaneous (70-30) 100 UNIT/ML 32 units ml Q a.m.
[illegible]semide Oral 20 MG 1 Tab(s) BID
[illegible]othyroxine Sodium Oral 100 MCG 1 Tab(s) daily
[illegible]spirin Oral 81 MG 1 Tab(s) daily
[illegible]orvastatin Calcium Oral 20 MG 1 Tab(s) daily
[illegible]EDipine ER Oral 60 MG 1 Tab(s) BID
[illegible]n Oral 28 MG 1 Tab(s) daily
[illegible]misartan-HCTZ Oral 80-12.5 MG 1 Tab(s) daily
[illegible]drALAZINE HCl Oral 100 MG 1 Tab(s) BID
Sodium Bicarbonate Oral 650 MG 1 Tab(s) BID
[illegible]llopurinol Oral 100 MG 1 Tab(s) daily
[illegible]loNIDine HCl Oral 0.3 MG 1 Tab(s) TID

[illegible] Parameters and Treatments (Continued)

Pulse greater than (>) 110 or less than (<) 50.
Respirations greater than (>) 28 or less than (<) 12.
Systolic BP greater than (>) 170 or less than (<) 90.
Diastolic BP greater than (>)100 or less than (<) 50.
O2 Sat less than (<) 88%.
Fasting blood sugar greater than (>) 250 or less than (<) 60.
[illegible]om blood sugar greater than (>) 350 or less than (<) 60.
[illegible] to assess patient's willingness to take pain medications and/or barriers to compliance, e.g., patient [illegible] unable to tolerate side effects such as drowsiness, dizziness, constipation.
[illegible] to report to physician if patient experiences pain level not acceptable to patient, pain level greater than 7, pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities.
SN to instruct the Patient/Caregiver on methods to reduce friction and shear.
SN to instruct Patient/Caregiver on wound care as follows:
[illegible]one required, wound care at wound care clinic.
[illegible]ther: sn to assessed/instructs on left arm av shunt, reort any s/sx of infection to physician.
SN to assess skin for breakdown every visit.
SN to instruct Patient/Caregiver on all aspects of diabetic management to include disease process, foot [illegible]ssessments, signs and symptoms of hypo/hyperglycemia, glucometer use and preparation and administration [illegible] diabetic medications ordered by physician.
[illegible] to instruct Patient/Caregiver to inspect patient's feet daily and report any skin or nail problems to [illegible].
SN to instruct Patient/Caregiver to wash patient's feet in warm (not hot) water. Wash feet gently and [illegible]at dry thoroughly making sure to dry between toes.
SN to give patient 4 oz of fruit juice or 1 tablespoon of sugar in H20 if blood sugar is 60 mg/dl or [illegible]elow, and recheck blood sugar in 15 to 20 minutes. If blood sugar remains 60 mg/dL or below, notify [illegible]hysician.
SN to instruct the patient the following symptoms could be signs of a heart attack: chest discomfort, [illegible]iscomfort in one or both arms, back, neck, jaw, stomach, shortness of breath, cold sweat, nausea, or [illegible]izziness. Instruct patient on signs and symptoms that necessitate calling 911.
SN to instruct Patient/Caregiver on diabetic diet, renal diet, heart healthy diet diet.
SN to assess patient for diet compliance.
SN to assess for changes in neurological status every visit.
SN to assess patient's compliance with home exercise program.
SN to instruct patient to wear proper footwear when ambulating.
SN to instruct the Patient/Caregiver to remove clutter from patient's path such as clothes, books, [illegible]shoes, electrical cords, or other items that may cause patient to trip.
SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury [illegible]and to call 911 for fall resulting in serious injury or causing severe pain or immobility.
SN to determine if the Patient/Caregiver is able to identify the correct dose, route, and frequency of [illegible]each medication.
SN to instruct the Patient/Caregiver on medication regimen dose, indications, side effects, and [illegible]interactions.
SN to instruct the Patient/Caregiver on precautions for high risk medications, such as, hypoglycemics, [illegible]anticoagulants/antiplatelets, sedative hypnotics, narcotics, antiarrhythmics, antineoplastics, skeletal [illegible]muscle relaxants.

[illegible] Identified Patient/Discharge Pl[illegible]s (Continued)

[illegible]atient skin integrity will remain intact during this episode.
[illegible]atient's fasting blood sugar will remain between 60 mg/dl and 250 mg/dl during the episode.
[illegible]atient's random blood sugar will remain between 60 mg/dl and 350 mg/dl during the episode.
[illegible]tient will be free from signs and symptoms of hypo/hyperglycemia during the episode.
[illegible] Patient/Caregiver will verbalize an understanding of skin conditions that must be reported to SN or [illegible]hysician immediately .
[illegible] Patient/Caregiver will verbalize understanding of proper diabetic foot care by: 05/26/2016.
[illegible]atient's blood pressure will remain within established parameters during the episode.
[illegible]atient will maintain diabetic diet, renal diet, heart healthy diet diet compliance during the episode.
[illegible]he Patient/Caregiver will demonstrate compliance with maintaining a diet log during the episode.
[illegible]atient will remain free from increased confusion during the episode.
[illegible]atient's mobility will be improved with assistance of physical therapist. *(Continued)*

Addendum Page

Post Hospital Order 04/08/2016

Turner, Erma G. (3730)
Date of Birth: 03/23/1933

Rehabilitation Potential/Discharge Plans (Continued)

The Patient/Caregiver will remove all clutter from patient's path, such as clothes, books, shoes, electrical cords, and other items, that may cause patient to trip by: 05/26/2016.
Patient will remain free of adverse medication reactions during the episode.
The Patient/Caregiver will be independent with medication management by: 05/26/2016.
The Patient/Caregiver will verbalize understanding of medication regimen, dose, route, frequency, indications, and side effects by: 05/26/2016.
The Patient/Caregiver will be able to verbalize an understanding of the indications for each medication by: 05/26/2016.
Rehab potential: Fair to achieve stated goals with skilled intervention and patient's compliance with the plan of care.
Discharge plans: Discharge when medical condition is stable and patient is no longer in need of skilled services.
Discharge to care of physician.
Discharge when goals met.
Discharge wher wound(s) healed.