Department of Health and Human Services Centers for Medicare & Medicaid Services

Form Approved OMB No. 0938-035

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
458948774A	06/24/2016	From: 08/23/2016 To: 10/21/2016	MW102450	679023

6. Patient's Name and Address
Wallace, Mildred
9308 BECK AVENUE # 107
Dallas, TX 75228
(214) 859-0227

7. Provider's Name, Address and Telephone Number
Vision Home Health Care Inc.
409 E CENTERVILLE ROAD # A
Garland, TX 75041
Phone: (214) 703-0767 | Fax: (214) 703-0765
Email: Vhhc210@yahoo.com

8. Date of Birth 10/24/1950

9. Sex ☐ M ☒ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged (U)nchanged
LISINOPRIL 40 MG ORAL TABLET 1 tab Twice/day By mouth (PO) U
AMIODARONE HYDROCHLORIDE 200 mg 1 tab Daily By mouth (PO) U

11.ICD- 10-CM I12.9	Principal Diagnosis: Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	E	Date 08/18/2016
12.ICD- 10-CM	Surgical Procedure		Date
13.ICD- 10-CM N18.9	Other Pertinent Diagnoses: Chronic kidney disease, unspecified	E	Date 08/18/2016

14. DME and Supplies
Cane, Alcohol Pads, Exam Gloves, Probe Covers

15. Safety Measures:
Fall Precautions, Instructed on disaster/emergency plan

16. Nutritional Req. Heart Healthy. Renal Diet. Fluid Restriction 1000

17. Allergies: NKA (Food/Drugs/Latex/Environment)

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

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

19. Mental Status: 1 ☒ Oriented 2 ☐ Comatose 3 ☒ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☒ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
Recertify for home health for the episode covering 08/23/2016 to10/21/2016. SN Frequency: 1w9. SN for VS, observation, assessment and evaluation of all body systems with special emphasis on disease processes, document and report significant changes in patients condition to physician and follow orders. SN for training/education for client/caregiver on the following and all other areas of knowledge deficit as identified as needed and until client/caregiver verbalizes understanding and follows directions: hypertensive chronic kidney disease, essential hypertension, hyperlipidemia, Client is on Renal dialysis and go to Towngate in Garland 3 time a week from 11.30 to 3.30 for dialysis. SN to notify MD of: Temperature greater than (>) 100 or less than (<) 96. Pulse greater than (>) 120 or less than (<) 60. Respirations greater than (>) 30 or less than (<) 12. Systolic BP greater than (>) 180 or less than (<) 90. Diastolic BP greater than (>) 100 or less than (<) 60. Homebound Status: Exhibits considerable & taxing effort to leave home; Unable to safely leave home unassisted; SN to develop individualized emergency plan with patient. SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs. SN to report to physician if patient experiences pain level greater than 6, pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities. SN to instruct Patient on heart healthy.

22. Goals/Rehabilitation Potential/Discharge Plans
SN Goals: Patient will have absence or control of pain as evidenced by optimal mobility and activity necessary for functioning and performing ADLs by the end of the episode. Patient will have increased mobility, self care, endurance, ROM and decreased pain by the end of the episode. Patient's strength, endurance and mobility will be improved. The patient will be free from falls during the episode. The Patient will verbalize understanding of medication regimen, dose, route, frequency, indications, and side effects by 10/21/2016. Patient will show improvement and stabilization of health as evidenced by stable V/S and pain management within certification period. Patient will have desired response and will adhere to medication/treatment regimen for the next 60 days.

23. Nurse's Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by: Mary Badger RN 08/19/2016

25. Date HHA Received Signed POT

24. Physician's Name and Address
Ketha, Sumana MD
2925 Skyway Circle North
Irving TX 75038
Phone: (972) 639-5838 | Fax: (972) 675-7310
NPI: 1356565865

26. Physician Certification Statement
I recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan. I estimate the duration of continued Home Health services for this patient to be _____ (Days/weeks/Months)

27. Attending Physician's Signature and Date Signed
S. Ketha Electronically Signed By Ketha,Sumana M.D. 12/31/2016

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.

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ADDENDUM TO: PLAN OF TREATMENT

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
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6. Patient's Name:	7. Providers Name
Wallace, Mildred	Vision Home Health Care Inc.

10. Medications
ISOSORBIDE DINITRATE 20 MG ORAL TABLET 3 times/day By mouth (PO) U
CLONIDINE 0.3 MG ORAL TABLET 1 tab 3 times/day By mouth (PO) U
HYDRALAZINE 10 MG ORAL TABLET 1 tab 3 times/day By mouth (PO) U
SIMVASTATIN 40 MG ORAL TABLET 1 tab Bedtime By mouth (PO) U
CALCIUM ACETATE 667 MG ORAL CAPSULE 3 cap 3 times/day with meals By mouth (PO) U
Hydrocodone 10 mg/acetaminophen 325 mg 1 tab Every 4 -6 hours PRN By mouth (PO) U
XANAX 0.5 MG ORAL TABLET 1 tab Bedtime PRN By mouth (PO) U

13. Other Diagnoses
I13.10 Essential (primary) hypertension (E) 08/18/2016
Z99.2 Dependence on renal dialysis (E) 08/18/2016
E78.5 Hyperlipidemia, unspecified (E) 06/24/2016

16. Nutritional Requirements
ml/24 hours.

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
renal diet diet. SN to instruct the Patient on proper ROM exercises and body alignment techniques. SN to instruct patient to wear proper footwear when ambulating. SN to instruct patient to use prescribed assistive device when ambulating. SN to instruct the Patient to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. SN to determine if the Patient is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Patient can verbalize an understanding of the indication for each medication. SN to instruct the Patient on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, sedative hypnotics, narcotics, antiarrhythmics, antineoplastics, skeletal muscle relaxants. PT offered patient declined SN to continue instructing on safety and fall precaution.

22. Goals/Rehabilitation Potential/Discharge Plans

Rehab Potential: Fair for stated goals.
Discharge plan: Patient will be discharged to self-care under physician supervision when caregiver willing and able to manage all aspects of patient's care when goals are met.

27a. Signature of Physician:	27b. Date:
S. Ketha Electronically Signed By Ketha,Sumana M.D.	12/31/2016
23. Optional Name / Signature of Nurse / Therapist	Date
Electronically Signed by: Mary Badger RN	8/19/2016

Form CMS-487 (U4)(4-87)