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./NPI
500000028095	08/08/2015	From: 06/03/2016 To: 08/01/2016	CHC3102	747092/1578647020

6. Patients Name and Address
LEVON WILLIAMS
2607 JEFFRIES STREET #304
DALLAS TX 75215 2148616455

7. Provider's Name, Address and Phone Number
Calvary Health Care, Inc
2840 KELLER SPRINGS ROAD # 801 CAROOLLTON TX
Phone: (214)6781950 Fax: (214) 678-1940

8. Date Of Birth 03/02/1947 **9. Sex** [X] M [ ] F

11. ICD-CM	Principal Diagnosis		Date
I10	Essential (primary) hyper	E	05/12/2016

12. ICD-CM	Surgical Diagnosis	Date

13. ICD-CM	Other Pertinent Diagnosis		Date
M15.0	Osteoarthritis	E	05/05/2016
M51.86	Intervertebral disc disor	E	05/05/2016
G89.21	Chronic pain due to traum	E	05/05/2016
S46.001	Injury of muscle(s) and t	E	03/24/2016

10. Medication: Dose/Frequency/Route (N)ew (C)hange
Diltiazem 90MG 1 Tablet Oral BID
Hydrochlorothiazide 25MG 1 Tablet Oral Daily
cloNIDine 0.1MG 1 Tablet Oral BID
Potassium Chloride 8MEQ 1 Tablet, Extended Release Oral Daily
acetaminophen-HYDROcodone bitartrate 325MG-10MG 1 Tablet Oral Bid

14. DME and Supplies Alcohol swabs,Gloves: Non-sterile,Probe Covers.

15. Safety Measures Use of Assistive Devices, Instructed on Emergency Plan, Keep Pathways Clear

16. Nutritional req. Heart Healthy Diet.

17. Allergies NKDA,NKFA, NO ENVIRONMENTAL AND LATEX

18.A Functional Limitations

1 [ ]	Amputation	5 [ ]	Paralysis	9 [ ]	Legally Blind
2 [ ]	Bowel/Bladder (Incontinence)	6 [ ]	Endurance	A [ ]	Dyspnea with Minimal Exertion
3 [ ]	Contracture	7 [X]	Ambulation	B [X]	Other Specify
4 [ ]	Hearing	8 [ ]	Speech		DYSPNEA WITH MODERATE EXERTION.

18.B Activities Permitted

1 [ ]	Complete Bed Rest	6 [ ]	Partial Weight Bearing	A [ ]	Wheelchair
2 [ ]	BedRest BRP	7 [ ]	Independent At Home	B [X]	Walker
3 [X]	Up As Tolerated	8 [ ]	Crutches	C [ ]	No Restriction
4 [ ]	Transfer Bed/Chair	9 [X]	Cane	D [ ]	Other Specify
5 [ ]	Exercise Prescribed				

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

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

21. Orders For Disciplines and Treatment (Specify Amount/Frequency/Duration)
Adverse Event: Fall Risk(Poor Balance/Weakness/Fall/Risk/Gait Abnormality), Adverse Event: Osteoarthritis(Joint pain/Tenderness/Stiffness/Locking), Adverse Event: HTN (BP Monitoring/Medication Administration).
PATIENT IS HOMEBOUND DUE TO MAXIMUM TAXING EFFORT FOR PATIENT TO LEAVE HOME, POOR ENDURANCE, SIGNIFICANT PAST HEALTH HISTORY, DEPENDENCE ON ASSISTIVE DEVICE FOR AMBULATION AND TRANSFERS DUE TO WEAKNESS, DIFFICULTY WALKING AND DEBILITY.
Emergency Code: IV

SN VISIT FREQUENCY : 1WK9 EFFECTIVE 06/03/2016.

1. SN to perform skilled assessment, observation, and evaluation of complete organ systems.

22. Goals/Rehabilitation Potential/Discharge Plan
Patient continue to be is at risk for falls and injury due to decreased strength, requires supervision and assistance for ADL/IADL's.
Patient unable to perform ADL/IADL's due to deconditioning and obesity, Patient gets PHC 24.5hrs/wk for assistance with safe ADL/IADL's.. Patient Blood pressure will be within physician parameter in 2 weeks and remain <160 systolic and <90 diastolic during the reminder of the cert period.
Patient will achieve a stable cardiac status as evidenced by vital signs with prescribed parameters by 08/01/2016.
Patient pain will be managed at 1-2 on a scale of 0-10 within 2weeks with medication/activity regimen and remain <2 for the reminder of the episode. Patient stated goal for pain is 0-1 on a scale of 0-10.
Patient will be free of fall or injury within 2 weeks and the reminder of the cert. period.

23. Nurse's Signature and Date of Verbal SOC Where Applicable
Digitally Signed by: OGALA CHRISTIAN, RN 05/31/2016

25. Date HHA Received Signed POT
06/27/2016

24. Physician Name and Address
KETHA, SUMANA MD NPI: 1962447805
2925 SKYWAY CIRCLE NORTH Tel: 9726395838
IRVING TX 750385960 Fax: 9726757310

26. I Certify/Recertify that this patient is confined to his or her home and needs intermittent nursing care, physical therapy and/or speech therapy or continous to need occupational therapy. The patient is under my care and i have authorized the services on this plan of care and will periodically review the plan. I certify that in my estimation continued services will be required for 60-Days.

27. Attending Physician's Signature and Date signed
S.Ketha M.D 06/27/2016

28. Anyone who misrepresents, falsify or conceal 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

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13. Other Pertinent Diagnosis

M54.2 Cervicalgia E 05/05/2016
R26.2 Difficulty in walking, not elsewhere classified E 12/01/2015
Z91.81 History of falling E 08/13/2015
F41.9 Anxiety disorder, unspecified E 10/02/2015
F17.200 Nicotine dependence, unspecified, uncomplicated E 10/02/2015
F10.10 Alcohol abuse, uncomplicated E 10/02/2015
K08.9 Disorder of teeth and supporting structures, unspecified E 10/02/2015

15. Safety Measures

Safety in ADLs, Instructed on Fall Precautions, Instructed on emergency/disaster plan/ve, Instructed caregiver to clear pathway, Emergency care plan, Fall precautions, Clear Pathways.

21. Orders for Discipline and Treatments(Specify amount/Frequency/Duration)

2. Skilled observation/assessment for patient with: Hypertension, Disc Disorder, Osteoarthritis, Chronic Pain Due To Trauma, Shoulder & Upper Arm Injury, Cervicalgia, Difficulty Walking, Fall History, Anxiety, Tobacco Use, Alcohol Abuse, Dental Disorder And Cough.
3. Skilled Nurse to instruct patient/caregiver on the following:
a. Clonidine Action/Side Effects, and any new or changed medications.
b. Disease Process of Hypertension to Include; S/S to Report, Management and Complications.
c. SN to Instruct Patient/CG on non-Pharm pain interventions. Report any pain >5/10 to physicians.
d. SN to Instruct Patient/Caregiver on sodium recommended for heart healthy diet.
e. SN to Instruct Patient/Caregiver on alternatives to sodium.
f. SN to Instruct patient/Caregiver on effects of diet non compliance on hypertension.

4. Notify physician of the following: SBP>160 or <90, DBP>90 or <60, HR>100 or <60, Resp>24 or <12, Temp>100.5 or <96.1 or pain >5/10 on scale of 0-10 after pharm/non-pharm intervention.

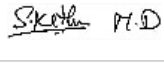
5. May accept orders from alternate physicians. Patient/SN may hold visit due to MD appointment, client request, hospitalization, and move out of service area, hold service for inpatient admission and resume services upon discharge from inpatient facility.
a. SN to use universal precautions at visit and during any procedures.
b. Patient gets PHC 24.5Hrs/Wk for Assistance with safe performance of ADL/IADL's.
c. SN may set up/administer medication if patient unable or caregiver unavailable.
d. Discharge summary available upon request.
e. SN to instruct patient/caregiver on any new diagnosis if patient is hospitalized.

VITAL SIGNS
Height: 5'10 Weight: 150lbs, Blood Pressure: 158/90 Temp: 98.2 Pulse: 96 Resp: 18 Pain: 3/10 Oxygen Saturation: 95%..

22. Goals/Rehabilitation potential/Discharge Plans

Patient will be Knowledgeable of medications regimen, effects, diets, safety, and home management of disease process as evidenced by verbalization by 08/01/2016.

Rehab Potential: Good for goals stated above.
DC Plan: Patient will be discharged when goals are met or alternative care has been arranged..

23. Optional Name/Signature Of Nurse/Therapist	Digitally Signed by: OGALA CHRISTIAN, RN	Date:	05/31/2016
27. Signature Of Physician:		Date:	06/27/2016