
3939 HWY 80 SUITE 375
MESQUITE, TX 75150
PH: 214-388-2300
F: 214-275-6499

# FAX

TO: DR. Kethra
FAX: 972-675-7310
PHONE: 972-675-7313
SUBJECT: orders

FROM: Sandy Baker Administrato
FAX: 214-275-6499
PHONE: 214-388-2300
DATE: 6/21/16

COMMENTS:

While reviewing chart for billing, the following orders require MD signature.

Thank You!

Have a great Day!

**Morning Star Quality Home Health Inc.**

3939 Highway 80

Mesquite, TX 751503354

Office:214-388-2300

Fax:214-275-6499

**Attending Physician:**

Dr. Sumana Ketha
2925 Skyway Cir
North Irving, TX 75038

**Office:** 972-675-7313

**Fax:** 972-675-7310

**Patient Information:**

**Name:** Thelma King
**Address:** 535 Buckingham
Apt 8203 2 nd Floor
Richardson, TX 75081
**Phone:** 214-664-5365
**ID:** 1-3033
**HIC #:** 467822719A
**DOB:** 10/23/1948
**Admit Date:** 09/16/2014
**Primary Diagnosis:**
(E11.21)TYPE 2 DM W/DIABETIC NEPHRO

## Physician Order

**Patient Name:** Thelma King

**Order ID:** 53384

**Begin Date:** 06/21/2016

**Projected End Date:**

**Discontinue Date**

**Disicipline/Med:** SN

**Order:** LATE CLARIFICATION ORDER FOR CERTIFICATION PERIOD 3/9/16 THRU 5/7/16.

DUE TO IMPROVMENT OF WOUND, SN TO DECREASE SKILLED NURSE VISITS FROM DAILYT TO 3X'S WEEKLY. SKILLED NURSE FREQUENCY SHOULD READ 1W1, 3W6, 4W1 BEGINNING 3/18/16.

V.O. SANDY BAKER LVN

**Clinical Signature:** Sandy Baker LVN
Baker,Sandy
**Date Signed:** 6/21/16

**Physician Signature:** S. Ketha Electronically signed by Ketha,Sumana M.D. on
Dr. Sumana Ketha
**Date Signed:** 06/05/2016

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

Form Approved
OMB No. 0938-0357

# 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. |
|---|---|---|---|---|
| 467822719A | 9/16/2014 | 3/9/2016 to 5/7/2016 | 1-3033 | 677804 |

**6. Patient's Name and Address**

Thelma F King
535 Buckingham
Apt 8203 2 nd Floor
Richardson, Texas 75081
214-664-5365 (Home)

**7. Provider's Name, Address and Telephone Number**

Morning Star Quality Home Health Inc.
3939 Highway 80
Ste. 375
Mesquite, Texas 751503354
214-388-2300 (Office)
214-275-6499 (Fax)

**8. Date of Birth**: 10/23/1948

**9. Sex**: Female

**10 .Medications: Dose/Frequency/Route (N)ew (C)hanged (cont. on 487)**

(L) NovoLIN 70/30 Subcutaneous Suspension (70-30) 100 UNIT/ML 75 Unit(s) Every am Subcutaneous
(L) NovoLIN 70/30 Subcutaneous Suspension (70-30) 100 UNIT/ML 55 Unit(s) Every pm Day(s) Subcutaneous
(L) NexIUM Oral Packet 40 MG 1 cap Every Day Oral
(L) Renvela Oral Tablet 800 MG 1 Tab(s) Three Times a Day Oral
(L) AmLODIPine Besylate Oral Tablet

| 11. ICD Code | Principal Diagnosis | Date |
|---|---|---|
| E11.21 | TYPE 2 DM W/DIABETIC NEPHROPATHY | 7/8/2015 (E) |

**12. ICD Code - Surgical Procedures - Date**

**13. ICD Code - Other Diagnoses - Date (cont. on 487)**

N18.6 - END STAGE RENAL DISEASE 7/8/2015 (E)

**14. DME and Supplies**

GLOVES

**15. Safety Measures (cont. on 487)**

Infection Control Precautions , Fall Precautions

**16. Nutritional Req.**

RENAL DIET

**17. Allergies (cont. on 487)**

Codeine Sulfate

**18.A. Functional Limitations**

1 ☐ Amputation
2 ☐ Bowel/Bladder
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☑ Endurance
7 ☑ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea
B ☐ Other (Specify)

**18.B. Activities Permitted**

1 ☐ Complete Bed Rest
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) (cont. on 487)**

SKILL NURSE 1DA10, 3 WEEK 7:

**22. Goals/Rehabilitation Potential/Discharge Plans (cont. on 487)**

Goals - PATIENT WOUNDS WILL HEAL BY END OF CERT PERIOD. PATIENT WILL BE KNOWLEDGEABLE OF DISEASE PROCESS.

**23. Nurse's Signature and Date of Verbal SOC Where Applicable:** Carolyn Stephens RN 3/8/16

**25. Date HHA Received Signed POT** RECEIVED 3/18/2016

**24. Physician's Name and Address**

Dr. Sumana Ketha NPI: 1962447805
2925 Skyway Cir
North Irving, Texas 75038
Office 972-675-7313
Fax 972-675-7310

26. 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.
I estimate continued services will be required for _____
The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

**27. Attending Physician's Signature and Date Signed**

S. Ketha Electronically signed by Ketha,Sumana M.D. on 06/25/2016

**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.**

Form CMS-485 (C-3)(02-94)(Formerly HCFA-485)

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

Form Approved
OMB No. 0938-0357

# Addendum to Plan of Care

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Morning Star Quality Home Health Inc.
3939 Highway 80
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Mesquite, Texas 751503354
214-388-2300 (Office)
214-275-6499 (Fax)

**8. Date of Birth** 10/23/1948

| Item No | |
|---|---|
| 10. | 10 MG 1 Tab(s) Every Day Oral<br>(L) Carvedilol Oral Tablet 25 MG 1 Tab(s) Every Day Oral<br>(L) Norco Oral Tablet 7.5-325 MG 1 Tab(s) Every 4-6 Hour(s) Oral prn pain<br>(N) Valsartan Oral Tablet 160 MG 1 Tab(s) Every Day Oral<br>(C) Levothyroxine Sodium Oral Tablet 75 MCG 1 Tab(s) Every Day Oral<br>(N) Triamcinolone Acetonide (Top) External Ointment 0.1 % Topical Twice a Day External<br>(N) Aquaphor External Ointment |
| 13. | I10 - ESSENTIAL PRIMARY HYPERTENSION 7/8/2015 (E)<br>L40.9 - PSORIASIS UNSPECIFIED 7/8/2015 (E)<br>M62.81 - MUSCLE WEAKNESS GENERALIZED 7/8/2015 (E)<br>L02.419 - CUTANEOUS ABSCESS LIMB UNSPECIFIED |
| 15. | , Clear Pathways , Safety in ADL's , Standard Precautions |
| 17. | Codeine Sulfate<br>Clindamycin HCl |
| 21. | SKILL NURSE FOR OBSERVATION, ASSESSMENT AND TEACHING REGARDING DISEASE PROCESS, MANAGEMENT & PREVENTIVE MEASURES & WHEN TO NOTIFY RN/MD. SKILL NURSE TO MONITOR VITAL SIGNS: BP > 175/90 OR , 90/50, TEMP . 100.8, PULSE > 120 OR , 60, RESP. > 24 OR < 12, FSBS > 350 OR < 60. SKILL NURSE TO ASSESS CARDIAC DISEASE PROCESS AND INSTRUCT CAREGIVER ON SIGNS AND SYMPTOMS OF COMPLICATION AND WHEN TO NOTIFY RN/MD. SKILL NURSE INSTRUCT PATIENT ON ALL ASPECTS OF MEDICATION REGIMEN IE; PURPOSE, SCHEDULE, ADVERSE REACTION NEW OR CHANGED MEDICATION. SKILL NURSE INSTRUCT PATIENT ON USE OF BLOOD SUGAR MONITOR. INSTRUCT ON ALL ASPECTS OF DISBETIC CARE, MANAGEMENT OF COMPLICATIONS, SKIN & FOOT CARE. ASSESS PATIENT ABILITY TO MANAGE DIABETIC DISEASE PROCESS & MEDICATION ADMINISTRATION. SKILL NURSE TO ASSESS HOME SAFETY AND INSTRUCT ON FALL AND INJURY PREVENTION.<br>SKILL NURSE TO PREFORM WOUND CARE EACH VISIT. WOUND CARE ORDERS: CLEAN WOUND TO BILATERAL EXTREMITIES BELOW THE KNEE WITH NORMAL SALINE, PAT DRY, APPLY THIN LAYER OF SILVER SULFADIAZINE CREAM 1% TO BOTH LEGS, WRAP WITH KERLIX AND SECURE WITH TAPE. SKILL NURSE INSTRUCT PATIENT ON S/SX OF COMPLICATION TO REPORT IF TEMP IS >100.8, INCREASE DRAINAGE, REDNESS OR FOUL ODOR. |
| 22. | PATIENT WILL BE KNOWLEDGEABLE OF DIABETES AND HOW IT AFFECTS THE BODY, S/SX OF COMPLICATION AND HOW TO MANGE DURING EPISODES OF ILLNESS OR STRESS AND DECREASE ACTIVITY.<br>PATIENT SAFETY WILL BE MAINTAINED AS EVIDENCE OF NO FALLS OR INJURIES.<br>PATIENT POTENTIAL FAIR FOR RETURN TO INDEPENDENT LIVING.<br>PATIENT WILL BE DISCHARGE WHEN SKILL SERVICES ARE NO LONGER NEEDED. |

**9. Nurse's Signature** Carolyn Leghorn RN **10. Date Signed** 3/8/16

**11. Attending Physician's Signature** **12. Date Signed**

S. Ketha Electronically signed by Ketha,Sumana M.D. on 06/25/2016

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



485ID: 52461

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

Form Approved
OMB No. 0938-0357

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214-388-2300 (Office)
214-275-6499 (Fax)

**8. Date of Birth**

10/23/1948

**9. Sex**

Female

| 11. ICD Code | Principal Diagnosis | Date |
|---|---|---|
| E11.21 | TYPE 2 DM W/DIABETIC NEPHROPATHY | 7/8/2015(E) |

**12. ICD Code - Surgical Procedures - Date**

**13. ICD Code - Other Diagnoses - Date**

N18.6 - END STAGE RENAL DISEASE 7/8/2015 (E)
I10 - ESSENTIAL PRIMARY HYPERTENSION 7/8/2015 (E)
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**10 .Medications: Dose/Frequency/Route (N)ew (C)hanged**

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(L) NovoLIN 70/30 Subcutaneous Suspension (70-30) 100 UNIT/ML 55 Unit (s) Every pm Day(s) Subcutaneous
(L) NexIUM Oral Packet 40 MG 1 cap Every Day Oral
(L) Renvela 800 MG Three Times a Day Oral (1 Tab(s) of 800 MG)
(L) AmLODIPine Besylate Oral Tablet 10 MG 1 Tab(s) Every Day Oral
(L) Carvedilol Oral Tablet 25 MG 1 Tab(s) Every Day Oral
(L) Norco Oral Tablet 7.5-325 MG 1 Tab(s) Every 4-6 Hour(s) Oral pm pain
(N) Valsartan Oral Tablet 160 MG 1 Tab(s) Every Day Oral
(C) Levothyroxine Sodium Oral Tablet 75 MCG 1 Tab(s) Every Day Oral
(N) Triamcinolone Acetonide (Top) External Ointment 0.1 % Topical Twice a Day External
(N) Aquaphor External Ointment

**14. DME and Supplies**

ALCHOLD PADS, GLOVES, DRESSING SUPPLIES

**15. Safety Measures**

Safety in ADL's , Assistive Devices , Standard Precautions

**16. Nutritional Req.**

NCS, RENAL DIET

**17. Allergies:**

Codeine Sulfate
Clindamycin HCl

**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 w/minimal exertion
B ☐ Other (Specify)

**18.B. Activities Permitted**

1 ☐ Complete Bed Rest
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

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# Home Health Certification and Plan of Care

Patient Name: Thelma King Cert Period: 5/8/2016 to 7/6/2016

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

SN VISIT FREQUENCY: 3W8, 2W1

***EMERGENCY CONTACT***WILLIE BILLOPS 469-939-8304

MAY ACCEPT ORDERS FROM ON CALL PHYSICIANS

SN TO ASSESS VS AND ALL BODY SYSTEMS, KNOWLEDGE OF DISEASE PROCESS AND ITS ASSOCIATED CARE AND TREATMENT, MED REGIMEN KNOWLEDGE, AND S/S OF COMPLICATIONS NECESSITATING MEDICAL ATTENTION.
SN TO IMPLEMENT AND INSTRUCT STANDARD PRECAUTIONS/INFECTION CONTROL.
SN TO IMPLEMENT AND INSTRUCT MANAGEMENT OF DISEASE PROCESS TO INCLUDE:DM TYPE II W/ DIABETIC NEUROPATHY, ESRD, HTN, CUTANEOUS ABSCESS OF LOWER LIMB.
SN TO IMPLEMENT AND INSTRUCT MEDICATION REGIMEN, INCLUDING DOSAGE, SIDE EFFECTS, NAME, ROUTE, FREQUENCY, DESIRED ACTION AND ADVERSE REACTIONS.
SN TO ASSESS MEDICATION COMPLIANCE.
SKILLED NURSE TO NOTIFY PHYSICIAN OF TEMPERATURE >101 OR <95, PULSE RATE >100 OR <50, SYSTOLIC B/P>160 OR <90, DIASTOLIC B/P >95 OR <50, RESPIRATIONS >24 OR <12.
SN TO ASSESS CHANGES IN LOC/NEUROLOGICAL STATUS.
SN TO ASSESS MUSCULOSKELETAL STATUS.
SN TO ASSESS/INSTRUCT INTERVENTIONS TO MONITOR AND MITIGATE PAIN.
SN TO REPORT TO MD IF PAIN IS > OR = 6/10 ON WONG-BAKER SCALE.
SN TO ASSESS RESPIRATORY STATUS.
SN TO ASSESS/INSTRUCT METHODS TO RECOGNIZE PULMONARY DYSFUNCTION AND RELIEVE COMPLICATIONS.
SN MAY ASSESS/INSTRUCT PULSE OXIMETRY PRN PER SYMPTOMOLOGY AND REPORT O2 SATS <90% TO MD.
SN TO ASSESS CARDIOVASCULAR STATUS.
SN TO ASSESS/INSTRUCT MEASURES TO RECOGNIZE CARDIAC DYSFUNCTION AND RELIEVE COMPLICATIONS.
USING STERILE SUPPLIES AND ASEPTIC TECHNIQUE, SN TO PERFORM WOUND CARE TO BILATERAL LOWER EXTERMITIES AS FOLLOWS:
TREATMENT:
1) SN TO CLEANSE WITH NORMAL SALINE
2) PAT DRY WITH GAUZE
3) APPLY THIN LAYER SILVER SULFADIAZINE 1% CREAME
4) WRAP WITH KERLIX
5) SECURE WITH TAPE AND TUBI GRIP
6) CHANGE DRESSING (FREQ) 3X/WEEK AND PRN FOR SOILING AND/OR DISLODGEMENT

SN TO TEACH PATIENT/CAREGIVER WOUND CARE PROCEDURE. PT/CG MAY ASSUME WOUND CARE RESPONSIBILITY ONCE WOUND CARE PROFICIENCY HAS BEEN DEMONSTRATED TO SN.
SN MAY DISCONTINUE WOUND CARE ONCE WOUND HAS HEALED.

SN TO ASSESS/INSTRUCT USE OF ELECTRONIC GLUCOSE MEASURING DEVICE.
SN TO ASSESS/INSTRUCT PT/CG DIABETIC CARE TO INCLUDE DIET, ACTIVITY, STRESS, FOOT CARE AND SKIN CARE.
SN TO ASSESS/INSTRUCT PT/CG DIABETIC FOOT CARE INCLUDING MONITORING FOR THE PRESENCE OF SKIN LESIONS ON THE LOWER EXTREMITIES AND PATIENT/CAREGIVER EDUCATION ON PROPER FOOT CARE.
SN TO ASSESS /INSTRUCT PT/CG ON S/S OF COMPLICATIONS OF DIABETES AND S/S OF HYPO/HYPERGLYCEMIA.
SN TO MONITOR GLUCOMETER RECORDINGS FOR VARIATIONS AND COMPLIANCE.
SN TO NOTIFY PHYSICIAN OF BLOOD SUGAR OVER 350 AND UNDER 60 MG/DL.
GLUCOMETER TESTING TO BE PERFORMED BY PATIENT AND CAREGIVER OR SKILLED NURSE IF NOT COMPLETED BY SN VISIT Q DAY AND PRN.
SN TO ASSESS/INSTRUCT FALL PREVENTION.
SN TO ASSESS FOR SIGNS/SYMPTOMS OF EXACERBATION RELATED TO COMORBIDITIES.

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OMB No. 0938-0357

# Home Health Certification and Plan of Care

Patient Name: Thelma King

Cert Period: 5/6/2016 to 7/6/2016

**22. Goals/Rehabilitation Potential/Discharge Plans**

THE PATIENT'S SAFETY WILL BE ENHANCED THROUGHOUT THE HOME CARE SERVICE AS EVIDENCED BY NO FALLS/INJURIES WITHIN9 WEEKS.
THE PATIENT/CAREGIVER WILL VERBALIZE UNDERSTANDING OF DM TYPE II WITH DIABETIC NEUROPATHY, ESRD, HTN, CUTANEOUS ABSCESS OF LOWER LIMBSAND ALL ASPECTS OF ASSOCIATED CARE WITHIN9 WEEKS.
THE PATIENT/CAREGIVER WILL VERBALIZE UNDERSTANDING OF NEW/CHANGED MEDICATIONS AS EVIDENCED BY RECALL OF ACTION DOSE AND SIDE EFFECTS WITHIN 9 WEEKS.
THE PATIENT/CAREGIVER WILL VERBALIZE UNDERSTANDING OF NCS, RENAL DIET AS EVIDENCED BY COMPLIANCE WITH DIET PLAN WITHIN 9 WEEKS.
THE PATIENT'S SKIN AND MUCOUS MEMBRANES WILL REMAIN INTACT FOR THIS CERT PERIOD.
THE PATIENT'S BLOOD SUGAR LAB VALUE WILL BE WITHIN NORMAL LIMITS PER PHYSICIAN ASSESSMENT AND PATIENT'S COMPLIANCE WITH MEDS/DIET THIS CERT PERIOD.
THE PATIENT'S PAIN WILL BE CONTROLLED AND MANAGED AT THE PATIENT'S OWN COMFORT LEVEL AS VERBALIZED BY THE PATIENT/CAREGIVER WITHIN 9 WEEKS.
THE PATIENT'S WOUND/INCISION SITE WILL BE DECREASED IN SIZE BY50 %THIS CERT PERIOD.
THE PATIENT'S HOME ENVIRONMENT WILL BE CLEAN AND SAFE, AS EVIDENCED BY NO INFECTGION NO INJURIES WITHIN9 WEEKS.
THE PATIENT WILL REMAIN FREE OF EXACERBATIONS RELATED TO COMORBIDITIES THIS CERT.
REHABILITATION POTENTIAL IS FAIR
PATIENT TO BE DISCHARGED WHEN SKILLED CARE NO LONGER NEEDED. PATIENT TO BE DISCHARGED TO THE CARE OF CAREGIVER
ESTIMATED SKILLED SERVICES TO BE REQUIRED FOR9 WEEKS

**23. Nurse's Signature and Date of Verbal SOC Where Applicable:** 5/6/2016

**25. Date HHA Received Signed POT**

**24. Physician's Name and Address**

Dr. Sumana Ketha NPI: 1962447805
2925 Skyway Cir
North Irving, Texas 75038
Office 972-675-7313
Fax 972-675-7310

**26.** 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.
I estimate continued services will be required for _____
The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

**27. Attending Physician's Signature and Date Signed**

S. Ketha Electronically signed by Ketha,Sumana M.D. on 06/25/2016

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