



LONESTAR
HOME HEALTH SERVICES

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HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No. 452401970B		2. Start Of Care Date 07/22/2015		3. Certification Period From: 07/16/2016 To: 09/13/2016		4. Medical Record No. LS625		5. Provider No. 679267	
6. Patient's Name and Address Pitman, Wanda 432 BROWN DR. Irving, TX 75061 (972) 986-9543					7. Provider's Name, Address and Telephone Number Lone Star Home Health Services 3129 ESTERS RD Irving, TX 75062 Phone: (214) 441-0791 Fax: (214) 441-0291 Email: terrill@lshhs.com				
8. Date of Birth 12/21/1933					9. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F				
10. Medications: Dose/Frequency/Route (N)ew (C)hanged (U)nchanged ALBUTEROL 2 PUFFS Q6HRS PRN WHEEZING PO CYMBALTA 60 MG 1 TAB DAILY PO									
11. ICD-10-CM Principal Diagnosis I25.10 Atherosclerotic heart disease of native coronary artery w/o ang pectoris								Date	
12. ICD-10-CM Surgical Procedure								Date	
13. ICD-10-CM Other Pertinent Diagnoses K21.9 Gastro-esophageal reflux disease without esophagitis								Date	
14. DME and Supplies Bedside Commode, Cane, Elevated Toilet Seat, Tub/Shower Bench,					15. Safety Measures: Fall Precautions, Keep Pathway Clear, Safety in ADLs, Standard				
16. Nutritional Req. Low Cholesterol, Low Fat, No Added Salt.					17. Allergies: NKA (Food/Drugs/Latex/Environment)				
18.A. Functional Limitations					18.B. Activities Permitted				
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 checked="" type="checkbox"/> Dyspnea With Minimal Exertion 3 <input type="checkbox"/> Contracture 7 <input checked="" type="checkbox"/> Ambulation B <input type="checkbox"/> Other (Specify) 4 <input type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech					1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Weight Bearing A <input checked="" type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Independent At Home B <input checked="" type="checkbox"/> Walker 3 <input 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 type="checkbox"/> Other (Specify) 5 <input type="checkbox"/> Exercises Prescribed 5 <input type="checkbox"/> Disoriented 7 <input type="checkbox"/> Agitated 6 <input type="checkbox"/> Lethargic 8 <input type="checkbox"/> Other 3 <input checked="" type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input type="checkbox"/> Excellent				
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				
20. Prognosis:					1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) SNV: 1W10 and 2 PRN to assess/instruct for unstable vital signs and/or exacerbation of disease process for duration of entire certification. SN for skilled observation / assessment of cardiopulmonary, GI, GU, musculoskeletal, integumentary, pain, neurological and nutritional status of the client at each visit. Notify physician of significant changes that warrant treatment plan modification including: SBP> 160 mmHg or <90 mmHg; DBP> 90 mmHg or <50mmHg; pulse >100/min. or, <60/min., respiration >26/min. or <12/min, and temperature >100F or <95F. Instruct/supervise client/CG in the following: Low Cholesterol, Low Fat, No Added Salt diet, disease process, precautions/ complications, and medication regimen including purpose, action, dosage, side effects or adverse reactions. Home safety precautions, emergency measures and signs/symptoms to report to the physician. SN to assess/instruct blood pressure, disease process instructs medications including potential side effects and adverse effects. SN to instruct Pt/CG on effect of stress on body/disease, managing stress, energy conservation and relaxation technique, Instruct on medication and diet compliance, daily exercise and medical follow up to control HTN. SN to assess for abdominal/gastric burning, pain or gastritis related GERD. Assess meds, diet activity regimen. Instruct on therapeutic diet and ways to relieve abdominal/ gastric discomfort. SN to instruct patient on warning signs of vertigo including light headed, sense of spinning or moving. SN to instruct patient to move, turn or rise from bed slowly to avoid fall/injury. SN to instruct/assess disease process, pain management, medications including									
22. Goals/Rehabilitation Potential/Discharge Plans SN Goals: Client's health status will remain stable within 9 weeks. Patient's blood pressure will remain within established parameters during the episode. Patient's respiration will be within the established parameters during the episode. Patient will be free of respiratory distress during this episode. Client's/CG knowledge of disease process and medication regimen will increase to substantial within nine weeks of service. Patient's pain will be controlled/managed and will be <=2/10 of pain scale with pain medication throughout this episode. Patient's safety will be enhanced as evidenced by no fall/injury during this episode. Patient will maintain Low Cholesterol, Low Fat, No Added Salt diet compliance during the episode. Patient will achieve optimal level of cardiovascular status within 60 days. Patient will exhibit no s/s of acid reflux, reflux,									
23. Nurse's Signature and Date of Verbal SOC Where Applicable: Electronically Signed by: Ammini Thomas RN 07/11/2016					25. Date HHA Received Signed POT				
24. Physician's Name and Address Ketha, Sumana MD 2925 Skyway Cir N Irving TX 75038 Phone: (972) 675-7313 Fax: (972) 675-7310 NPI: 1962447805					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 <u>4</u> (Days/weeks/Months)				
27. Attending Physician's Signature and Date Signed <u>S. Ketha</u> Electronically signed by Ketha, Sumana M.D. on 07/18/2016					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.				

07/18/2016

Department of Health and Human Services
Centers for Medicare/Medicaid ServicesForm Approved
OMB No. 0938-0357

ADDENDUM TO: PLAN OF TREATMENT

1. Patient's HI Claim No. 452401970B	2. Start Of Care Date 07/22/2015	3. Certification Period From: 07/16/2016 To: 09/13/2016	4. Medical Record No. LS625	5. Provider No. 679267
6. Patient's Name: Pitman, Wanda		7. Providers Name Lone Star Home Health Services		
10. Medications ALPRAZOLAM 0.25 MG 1 TAB TID PO PRN ANXIETY CLONIDINE 0.1 MG 1 TAB Q 8HRS PO PRN FOR BP>140/90 ZOLPIDEN TARTRATE 5 MG 1 TAB Q HS PO LEVOTHYROXINE 25 MCG 1 TAB DAILY PO NEXIUM 40 MG 1 CAP DAILY PO MECLIZINE 25 MG 1 TAB Q 8HRS PO PRN VERTIGO ASPIRIN 81 MG 1 TAB DAILY PO PROMETHAZINE 25 MG SUPP Q6HRS RECTALLY PRN NAUSEA NITROSTAT 0.4 MG 1 TAB PRN SL CHEST PAIN FORTEO (TERIPARATIDE) 20 MCG DAILY SQ TRAVATAN 0.004% 1 DROP DAILY LEFT EYE PILOCARPINE 1 DROP TID LEFT EYE BRIMONIDINE TARTRATE 1 DROP DAILY EACH EYE Zantac Hcl 150 mg BID oral N HYDROCODONE 10/325 MG 2 TAB Q6HRS PO PRN PAIN TRAMADOL 50 MG ORAL 1 TAB Q 6 HRS PRN, PAIN VOLTAREN TOPICAL 1% TOPICAL GEL TID ATROVASTATIN 40 MG (LIPITOR) 1 TAB Q HS PO LYRICA 150 MG TID PO oxybutynin ER 10 mg Daily, P.O ALBUTEROL 2 PUFFS TID PO PROPRANOLOL 60 MG TID PO DICYCLOMINE 20 MG ORAL 1 TABLET q 6 hourly prn GI upset ZOFRAN 4 MG ORAL 1 TABLET q 6 hourly prn, NAUSEA MELOXICAM 15 MG BID PO				
13. Other Diagnoses H81.49 Vertigo of central origin, unspecified ear M19.90 Unspecified osteoarthritis, unspecified site F32.9 Major depressive disorder, single episode, unspecified G90.09 Other idiopathic peripheral autonomic neuropathy H26.9 Unspecified cataract M12.9 Arthropathy, unspecified M32.9 Systemic lupus erythematosus, unspecified I20.9 Angina pectoris, unspecified Z86.73 Prsnl hx of TIA (TIA), and cereb infrc w/o resid deficits I10 Essential (primary) hypertension				
14. DME and Supplies Walker, Wheelchair, Alcohol Pads, Exam Gloves, Probe Covers				
15. Safety Measures Precautions/Infection Control, Use of Assistive Devices, Instructed on mobility safety, Instructed on safety measures				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) side effects and adverse effects. SN has to instruct patient to avoid sitting or standing too long to avoid joint pain/stiffness. SN to monitor for significant findings, behaviors and s/s related to depression and report to physician. SN to assess/instruct and monitor medication effects/side effects and encourage compliance with same. SN to instruct patient in chest pain s/s including sudden chest pain feel like chest tightness, squeezing, crushing, burning, may radiate to shoulder and arms, treatment will be to take Nitrostat sublingually, not more than 3 in 15 minutes for single episode. If no relief call 911. SN to administer medications as ordered by physician, if not taken by patient and available. SN to fill med box if not by CG/patient. SN to assess O2 sat as needed for SOB. Notify MD if Sat is <90%. SN to assess for pain every visit. Notify MD if pain level >5 on the scale of 0-10. SN to instruct patient to take pain medicine before pain gets too intense to achieve better pain control. SN				
27a. Signature of Physician:  Electronically signed by Ketha, Sumana M.D. on			27b. Date: 07/18/2016	
23. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Ammini Thomas RN			Date 7/11/2016	

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

Form Approved
OMB No. 0938-0357

APPENDUM TO: PLAN OF TREATMENT

1. Patient's HI Claim No. 452401970B	2. Start Of Care Date 07/22/2015	3. Certification Period From: 07/16/2016 To: 09/13/2016	4. Medical Record No. LS625	5. Provider No. 679267
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6. Patient's Name: Pitman, Wanda	7. Providers Name Lone Star Home Health Services
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21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
to instruct patient/Cg on factors that contribute SOB, including avoiding the outdoors on poor air quality days. SN to instruct patient on energy conserving measures including frequent rest periods, small frequent meals, controlling stress. SN to perform a neurological assessment each visit. SN to assess for skin integrity every visit. SN to instruct patient to use prescribed assistive device when ambulating. SN may take orders from other pertaining physicians. HHA: 2W8,1w1 starting the week of 7/18/16 to assist/provide with ADL's.

22. Goals/Rehabilitation Potential/Discharge Plans
Patient will verbalize activities/foods that produce burning or gastric discomfort and patient will understand related medication for the next 60 days. Patient will be free of chest pain or chest pain will relieve with Nitrostat during the episode. Neuro status will be within normal limits and free of S&S of complications or further deterioration. Patient will verbalize energy conservation measures for the next 60 days. Patient will demonstrate and verbalize medications compliance/ effectiveness and patient's depression will improve for the next 60 days. HHA GOALS: 1) Safe personal care throughout episode. 2) Client/CG will be independent of personal care by end of episode. Rehabilitation Potential: Fair to achieve stated goals with skilled intervention and patient's compliance with the plan of care. Discharge Plans: to self-care/physician supervision when goals met and client no longer requires skilled intervention. Discharge summary available to physician upon request.

27a. Signature of Physician:
S. Ketha Electronically signed by Ketha, Sumana M.D. on

27b. Date:
07/18/2016

23. Optional Name / Signature of Nurse / Therapist
Electronically Signed by: Ammini Thomas RN

Date
7/11/2016

Lone Star Home Health Services
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PHYSICIAN ORDER**Patient: Pitman, Wanda**

432 Brown Dr.
Irving, Tx 75061
(972) 986-9543
HIC: 452401970B

MRN: LS625**DOB:** 12/21/1933**Physician: Ketha, Sumana MD**

2925 Skyway Cir N
Irving, Tx 75038

Phone: (972) 675-7313 | Fax: (972) 675-7310
NPI: 1962447805

Order Date: 7/11/2016 **Order #:** 24656855 **Episode Associated:** 5/17/2016—7/15/2016**Allergies:** NKA (Food/Drugs/Latex/Environment)**Summary:** Verbal order

SN to re-certify patient for home health care for the cert period of 7/16/16 to 9/13/16 SN to continue assess and monitor patient's vital signs, pain, cardiopulmonary, neurological status, Notify physician any significant changes. SN to continue educate patient on diet, medication use and compliance, home safety and fall precaution. Provide HHA to assist with ADL 's.

☒ Order read back and verified.**Clinician Signature:**

Electronically Signed by: Ammini Thomas RN

Date:

7/11/2016

Physician Signature:*S. Ketha* Electronically signed by Ketha, Sumana M.D. on**Date:**

07/18/2016