


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

Form Approved OMB No. 0938-0357

**HOME HEALTH CERTIFICATION AND PLAN OF CARE**

1. Patient's HI Claim No. 467151315a		2. Start Of Care Date 10/07/2016		3. Certification Period From: 10/07/2016 To: 12/05/2016		4. Medical Record No. DEHS0000000056		5. Provider No. 747372	
6. Patient's Name and Address Page, Victor 1826 SOUTH CORINTH RD Dallas, TX 75203 (214) 545-7649					7. Provider's Name, Address and Telephone Number Divine Edge Health Services LLC 8330 LBJ FREEWAY Suite 345 Dallas, TX 75243 Phone: (214) 493-3118   Fax: (888) 958-2383 Email: health@divineedgeservices.com				
8. Date of Birth 05/25/1970					9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F				
10. Medications: Dose/Frequency/Route (N)ew (C)hanged (U)nchanged ZYPREXA 10 MG ORAL TABLET 1 tab by mouth twice daily By mouth (PO) N DESYREL 100 MG ORAL TABLET 1 tab By mouth (PO) N									
11. ICD- 10-CM Principal Diagnosis I11.0		Hypertensive heart disease with heart failure						Date E 10/07/2016	
12. ICD- 10-CM Surgical Procedure I50.43		Acute on chronic combined systolic and diastolic hrt fail						Date E 10/07/2016	
14. DME and Supplies Cane, Probe Covers					15. Safety Measures: Fall Precautions, Safety in ADLs, Slow Position Change, Instructed on				
16. Nutritional Req. Heart Healthy, Low Fat.					17. Allergies: NKA (Food/Drugs/Latex/Environment)				
18.A. Functional Limitations					18.B. Activities Permitted				
1 <input type="checkbox"/> Amputation 2 <input type="checkbox"/> Bowel/Bladder (Incontinence) 3 <input type="checkbox"/> Contracture 4 <input checked="" type="checkbox"/> Hearing 5 <input type="checkbox"/> Paralysis 6 <input checked="" type="checkbox"/> Endurance 7 <input checked="" type="checkbox"/> Ambulation 8 <input type="checkbox"/> Speech 9 <input type="checkbox"/> Legally Blind A <input checked="" type="checkbox"/> Dyspnea With Minimal Exertion B <input type="checkbox"/> Other (Specify)					1 <input type="checkbox"/> Complete Bedrest 2 <input type="checkbox"/> Bedrest BRP 3 <input checked="" type="checkbox"/> Up As Tolerated 4 <input type="checkbox"/> Transfer Bed/Chair 5 <input type="checkbox"/> Exercises Prescribed 6 <input type="checkbox"/> Partial Weight Bearing 7 <input type="checkbox"/> Independent At Home 8 <input type="checkbox"/> Crutches 9 <input type="checkbox"/> Cane A <input type="checkbox"/> Wheelchair B <input type="checkbox"/> Walker C <input type="checkbox"/> No Restrictions D <input type="checkbox"/> Other (Specify)				
19. Mental Status:					1 <input checked="" type="checkbox"/> Oriented 2 <input type="checkbox"/> Comatose 3 <input checked="" type="checkbox"/> Forgetful 4 <input checked="" type="checkbox"/> Depressed 5 <input type="checkbox"/> Disoriented 6 <input type="checkbox"/> Lethargic 7 <input type="checkbox"/> Agitated 8 <input type="checkbox"/> Other				
20. Prognosis:					1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded 3 <input type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input type="checkbox"/> Excellent				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) SN Frequency: 2W1,1W8, 2PRN as needed for exacerbations. PT Frequency: Declined. SN to set up medication Minder every week. SN to notify MD of: Temperature greater than ( > ) 101 or less than ( < ) 95. Pulse greater than ( > ) 90 or less than ( < ) 60. Respirations greater than ( > ) 28 or less than ( < ) 12. Systolic BP greater than ( > ) 180 or less than ( < ) 90. Diastolic BP greater than ( > ) 100 or less than ( < ) 60. O2 Sat (percent) less than ( < ) 90. SN to assess patient for diet compliance. Pain greater than 6. Agency may accept orders from consulting Physicians, other doctors or specialist for the care of this Patient. Agency to Hold Home health services if patient transfers to inpatient facility and resume services when the patient returns home. SN to perform the following assessments every visit: EENT, CV Resp. Neuro, Skin, Musculoskeletal, GI, and GU status. Patients' home safety, fall risk and document deviations; Patients pain level every visit using the pain scale. 0= no pain, 10= unbearable pain. SN instruct pt. on pain and pain management. SN to instruct the Pt/Cg on Hypertensive heart disease, the disease process, pathophysiology, S/Sx such as Shortness of breath, Difficulty in sleeping flat on bed or suddenly waking up due to problems in breathing, Fatigue or weakness when doing ordinary or daily activities, Bloating and edema of the lower extremities, Nausea, Palpitations or irregular pulses, Coughing with frothy, pinkish secretion, Increased frequency of urination at night, headaches, dizziness, elevated blood pressure, Exacerbations, medications, indications of usage with side effects.									
22. Goals/Rehabilitation Potential/Discharge Plans The patient will have no hospitalizations and Vital signs will be within the normal limit during the episode. The Pt/cg will verbalize understanding of Hypertensive heart disease, the disease process, pathophysiology, S/Sx, Exacerbation's, medications, indications of usage with side effects, Treatments and prescribed instruct on prescribed diet of low fat, low cholesterol and low sodium, hearty diet by EOE. The Pt/cg will verbalize understanding of cardiac dysfunction and relieve complications by the end of the episode. Pt/Cg will verbalize understanding of symptoms could be signs of a heart attack: chest discomfort, discomfort in one or both arms, back, neck, jaw, stomach, shortness of breath, cold sweat, nausea, or dizziness. Instruct patient on signs and symptoms that necessitate calling 911 by the end of the									
23. Nurse's Signature and Date of Verbal SOC Where Applicable: Electronically Signed by: Oluyemisi Akinode RN 10/07/2016					25. Date HHA Received Signed POT				
24. Physician's Name and Address KETHA, SUMANA 2925 SKYWAY CIR. NORTH, IRVIN TX 75038 Phone: (972) 675-7313   Fax: (972) 675-7310 NPI: 1962447805					26. Physician Certification Statement I certify 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.				
27. Attending Physician's Signature and Date Signed  Electronically signed by Ketha, Sumana M.D. on 11/16/2016					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. 467151315a	2. Start Of Care Date 10/07/2016	3. Certification Period From: 10/07/2016 To: 12/05/2016	4. Medical Record No. DEHS0000000056	5. Provider No. 747372
6. Patient's Name: Page, Victor		7. Providers Name Divine Edge Health Services LLC		
10. Medications MOTRIN 600 MG ORAL TABLET 1 TAB EVERY 6 HOUR AS NEEDED FOR PAIN. By mouth (PO) N LISINOPRIL 10 MG ORAL TABLET 1 tab by mouth daily By mouth (PO) N				
13. Other Diagnoses F20.1 Disorganized schizophrenia (E) 10/07/2016 M15.0 Primary generalized (osteo)arthritis (E) 10/07/2016 G47.09 Other insomnia (E) 10/07/2016 G89.4 Chronic pain syndrome (E) 10/07/2016 R32 Unspecified urinary incontinence (E) 10/07/2016				
15. Safety Measures mobility safety				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) Treatments and prescribed instruct on prescribed diet of low fat, low cholesterol and low sodium, hearty diet. SN to instruct the Patient/Caregiver on measures to recognize cardiac dysfunction and relieve complications. SN to instruct patient on measures to detect and alleviate edema. SN to instruct Schizophrenia, mood disorder, home precautions/safety, fall/safety precautions. SN to instruct the patient the following symptoms could be signs of a heart attack: chest discomfort, discomfort in one or both arms, back, neck, jaw, stomach, shortness of breath, cold sweat, nausea, or dizziness. Instruct patient on signs and symptoms that necessitate calling 911. SN to instruct the Patient/Caregiver to remove clutter from patient's path that may cause patient to trip. SN to instruct the Patient/Caregiver 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/Caregiver is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Patient/Caregiver can verbalize an understanding of the indication for each medication. Homebound Status: Exhibits considerable & taxing effort to leave home; Severe Dyspnea; Unable to safely leave home unassisted; SN to develop individualized emergency plan with patient.				
22. Goals/Rehabilitation Potential/Discharge Plans episode. 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 be free from respiratory distress signs and symptoms of during the episode. Patient will remain free from chest pain, or chest pain during the episode. The Patient/Caregiver will verbalize and demonstrate edema-relieving measures by the episode. Patient will remain free of adverse medication reactions during the episode. Pt/cg will be able to list 2 of 4 uses of hypertensive heart disease medications within 60 days. Pt/cg will be able to list 2 of 3 names of meds within 60 days. The patient will be free falls and injury during the episode. The Patient/Caregiver will verbalize understanding of medication regimen, dose, route, frequency, indications, and side effects by EOE. Patient will remain free from increased confusion and mood will be as stable as possible, (pt. has schizophrenia) during the episode. Rehab Potential: Fair for stated goals. Discharge Plan: Patient to be discharged to Self care. Discharge when caregiver willing and able to manage all aspects of patient's care. Discharge when goals met				
27a. Signature of Physician: <i>S. Ketha</i> Electronically signed by Ketha, Sumana M.D. on			27b. Date: 11/16/2016	
23. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Oluyemisi Akinode RN			Date 10/7/2016	

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