Order #: 50401380

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Agency Information:
Marie Star Home Health Services
1849 Willow Pass Rd. Suite 306
Concord CA 94520-2524
9256914981 (Office), 9256914929 (Fax)

Patient HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
5HC9Q03NX40	10/8/2022	10/8/2022 - 12/06/2022	00348	059518

Patient Name, Address, and Phone Number
Jimenez, Aida 11/28/1940 Female
2517
Shamrock, drive
SAN PABLO,CA 94806
Mobile: 5108370517

Attending Physician or Allowed Practitioner Name and Address
CHEN, WILLIAM MD NPI: 1851498372
2089 Vale Rd #34
San Pablo CA 94806
(510) 235-9247 (Office), (510) 235-9248 (Fax)

Prognosis
Fair

Allergies
No Known Medication, Food, Animal, Plants or Environmental Allergy

Mental/Cognitive Status
Oriented to self and place

Nutritional Requirements
No Concentrated Sweets, No Added Salt, Mechanical Soft

Functional Limitations
Bladder incontinence

Activities Permitted/Restricted
No restrictions, Up as tolerated, Walker, Wheelchair, Human assistance required

Safety
24 Hour Supervision, Diabetic: Do Not Cut Nails, Fall Precautions, Safety in ADLs, Sharps Safety, Slow Position Changes, Support During Transfer and Ambulation, Use of Assistive Devices

DME and Supplies
DME: Walker, Cane
Durable Medical Equipment Provider:
Name:
Phone:
DME/Supplies Provided:

Advanced Directives
This patient does not have an advanced care plan or a surrogate decision maker and is not able to provide legal documentation for the home health medical record.

Caregiver Status
The patient's son Jeff is the primary caregiver. He works evening and other family members are available during the evening. The plan is to educate Jeff and the primary caregiver for the evening.

Psychosocial Status
No problems identified

Emergency Preparedness
Emergency Triage: 4. Visits could be postponed 72-96 hours without adverse effects (i.e., post op with no open wound, anticipated discharge within the next 10-14 days, routine catheter changes).

Medications
ACETAMINOPHEN 325 MG ORAL TABLET, DISINTEGRATING 325 mg Take two (2) tablets every six hours as needed for pain. Not to exceed 3 grams in 24 hours By mouth (PO) N
FERROUS SULFATE 325 MG (65 MG ELEMENTAL IRON) ORAL TABLET 324 Mg Take two (2) tablets daily for anemia By mouth (PO) N
ROSUVASTATIN-EZETIMIBE 10 MG-10 MG ORAL TABLET 10 Mg Take one tablet at bedtime for Dyslipidemia By mouth (PO) N
HUMALOG KWIKPEN 100 UNITS/ML INJECTABLE SOLUTION 100 Units for ML Sliding Sc
If Blood Sugar is less than 70 call MD
If Blood Sugar is 70 t 150 give 0 Units
If Blood Sugar is 151 to 200 give 1
If Blood Sugar is 201 to 250 give 2 Units
If Blood Sugar is 251 to 300 give 3 Unit
If Blood Sugar is 301 to 350 give 4 Units

Nurse/Therapist Signature And Date Of Verbal SOC Where Applicable	Date HHA Received Signed
Electronically Signed by: Hilda Smith MSNRN 10/8/2022	10/13/2022

Certifying Physician or Allowed Practitioner Name and Address
Chen, William MD NPI: 1851498372
2089 Vale Rd #34
San Pablo CA 94806
(510) 235-9247 (Office), (510) 235-9248 (Fax)

Physician or Allowed Practitioner Statement
I certify/recertify that this patient is confined to his/her home (as outlined in section 30.1.1 in Chapter 7 of the Medicare Benefit Policy Manual) and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan. The patient had a face-to-face encounter with an allowed provider type on 10/06/2022 and the encounter was related to the primary reason for home health care.

Physician Signature or Allowed Practitioner (Applies to total pages)	Signature Date
X	10/12/22

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If Blood Sugar is 351 to 400 give 5 Unit
subcutaneous (SQ) N
HUMALOG KWIKPEN 100 UNITS/ML INJECTABLE SOLUTION 100 units Sliding Scale (cont)
If Blood Sugar is greater than 400, give 6 Units
If Blood Sugar is greater than 400 cll MD
Take Blood Sugar before Breakfast Lunch, Dinner and Bedtime subcutaneous (SQ) C
LANTUS SOLOSTAR PEN 100 UNITS/ML SUBCUTANEOUS SOLUTION 10 Units Inject ten (10) at bedtime for Diabetes Mellitus 2. DO NOT MIX WITH ANY OTHER INSURIN subcutaneous (SQ) N
ZOFRAN ODT 4 MG ORAL TABLET, DISINTEGRATING 4 MG Place one (1) tablet on tongue and let dissolve every eight (8) hours as need for nausea Lingual N
SENNA (SENNOSIDES) 8.6 MG ORAL TABLET 8.6 Mg Take one (1) tablet daily if no bowel movement in 2 days. PRN

By mouth (PO) N
AMLODIPINE 5 MG ORAL TABLET 5Mg Take one (1) tablet daily By mouth (PO) N

ICD-10 CM Principal Diagnosis
E11.65 Type 2 diabetes mellitus with hyperglycemia

ICD-10 CM Other Diagnosis
M62.50 Muscle wasting and atrophy, NEC, unsp site
R26.89 Other abnormalities of gait and mobility
G93.49 Other encephalopathy
N18.4 Chronic kidney disease, stage 4 (severe)
I10 Essential (primary) hypertension
N17.9 Acute kidney failure, unspecified
E78.5 Hyperlipidemia, unspecified
Z79.4 Long term (current) use of insulin
Z74.1 Need for assistance with personal care

Orders For Discipline and Treatment
Notify Physician of vital sign parameters out of range:
Heart Rate: Greater Than (>) 120 Less Than (<) 60
Temp: Greater Than (>) 100 Less Than (<) 97 Respirations: Greater Than (>) 22 Less Than (<) 12 Pain Level: Greater Than (>) 5 O2 Saturation: Less Than (<) 90 Systolic BP: Greater Than (>) 170 Less Than (<) 90
Diastolic BP: Greater Than (>) 90 Less Than (<) 60 Blood Sugar, Fasting: Greater Than (>) 200 Less Than (<) 60 Blood Sugar, Random: Greater Than (>) 250 Less Than (<) 60
Frequency:
SN Frequency: 1w1, 3w2, 1w5, 3PRN diabetes and health problems
PT Frequency: Eval
HHA Frequency: 2w8

Nursing

Patient assessed to be at high risk for emergency department visits and/or hospital readmission. All necessary interventions to address the underlying risk factors are as follows: Ensuring that medications/insulin is available. Educate the family in the signs and symptoms of hyperglycemia and hypoglycemia. Educate the family regarding dosage and time of medications and taking and recording blood glucose and blood pressures, especially prior to administration of medications. Physical Therapy for strengthen and safe mobility.
SN to minimize/eliminate risk for hospitalization due to prior hospitalization.
SN to minimize/eliminate risk for hospitalization due to identified problems with medications especially the use of insulin, risk associated with insulin. She is one four po medications, requiring help with managing medications and noncompliance with medication regimen.

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SN to assess musculoskeletal status, identify any signs and symptoms of impaired functional status. SN to instruct patient on disease process, including who to contact if signs and symptoms persist or worsen as well as dietary measures, medication management and activities permitted. Assess joint pain/swelling and s/s of complications related to decreased mobility.
Additional Musculoskeletal Orders:

Home Health Aide to provide assistance with personal care and ADLs as indicated by limitations on functional and physical status impeding self-care.
SN to assess diabetic status, identify any signs and symptoms of impaired diabetic function, report significant changes to physician.
SN to instruct patient on self-management program to include, disease process, who to contact if signs and symptoms persist or worsen as well as dietary measures, medication management, foot care precautions, blood sugar monitoring, hypo/hyperglycemia management and long-term complications.
SN to prepare/teach patient/caregiver to administer insulin [dosage and freq] using aseptic technique.

SN to perform medication review each skilled nursing visit and reconcile medications as indicated. SN to instruct on all new and changed medications and reinforce teaching related to use of medications as part of disease process or demonstration of knowledge deficit.
SN to instruct patient/caregiver on new and/or changed medications and any other identified knowledge deficits as it relates to management of medication regimen.

Physical Therapy to assess functional status, home environment to eliminate structural barriers and improve safety and functional independence. PT to assess rehabilitation potential and determine need for gait training, safety precautions, pain management, strengthening/conditioning exercise, balance/ coordination and transfers. PT to establish a home exercise program and plan of care as approved by physician. May obtain O2 saturation as needed for s/s of possible respiratory distress.

Goals
Patient's personal healthcare goal(s):
The personal goals for the case is more of educating the family to enhance required care for the patient .
Nursing
Patient will demonstrate Adherence to Rehab program for Muscle weakness and fall potential, including compliance with HEP, identification of needed home modifications and use of adaptive devices by November 26, 2023.
Patient will demonstrate return to stable musculoskeletal status related to muscle weakness with improvement/maintenance of maximal level of functioning by November 26, 2022.
Patient will be free from falls/injury during this episode of care.
Caregiver demonstrate ability to effectively manage medication regimen November 26, 2022.
Patient will maintain blood sugar within normal range by end of episode as evidenced by reading within therapeutic range and Hemoglobin A1c at November 26, 2022.
Physical Therapy evaluation will be performed and a plan of care to increase functional independence will be established and countersigned by physician.
Patient will be free of skin breakdown during this episode of care.
Patient will receive safe and effective personal care during this episode of care.
Patient will be free of injury during this episode of care.
Patient will have no acute care hospitalizations, ER visits nor readmissions during this episode of care.

Rehabilitation Potential and Discharge Plan
Nursing
Rehabilitation Potential: Rehabilitation potential fair for treatment plan implementation
Discharge To Care Of: Caregiver

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Discharge When: Caregiver demonstrate necessary skills aid patient in managing disease process including medication management, when to notify physician, s/s necessitating emergent care, nutrition and activity.
Caregiver able to perform Diabetic Care without prompting and demonstrate ability to manage care, medications, s/s to report and when to notify physician.

Homebound Narrative
Patient is exhibiting a considerable and taxing effort to leave home due to cognitive level and level of weakness.

Medical Necessity
Caregiver with identified knowledge deficits regarding medication regimen management thereby increasing risk for injury and/or hospital risk; requiring skilled observation/assessment and teaching/training skills to improve self-management.

F2F Addendum (Admission Narrative)
Common symptoms of diabetes:
Urinating often
Feeling very thirsty
Feeling very hungry - even though you are eating
Extreme fatigue
Blurry vision
Cuts/bruises that are slow to heal
Weight loss - even though you are eating more (type 1)
Tingling, pain, or numbness in the hands/feet (type 2) -

Other Physicians On The Case

Optional Name/Signature of Nurse/Therapist	Signature Date and Time
Physician or Allowed Practitioner Signature (Applies to total pages) X	**Signature Date** 10/12/22