Government of the District of Columbia
Department of Health Care Finance
Division of Long-Term Care

Plan of Care for Medicaid Personal Care Aide (PCA), Home Health Aide and/or Skilled Nursing Services

To be completed by the Licensed Home Health Agency (DC Medicaid Provider). Please print clearly and complete all sections. If you have questions about this form, please call DHCF at (202) 724-4282.

Name Of Home Health Agency: T & N RELIABLE NURSING CARE, LLC

Address: 3500 18th ST NE , Washington, DC, 20018-

Phone (202) 529-6510 Fax (202) 529-6570

Signature of RN completing form: Vera Ogbu / RN Date: 9/13/13

Start of Care date: 9/13/2013

Plan of Care Certification Period: From: 9/13/2013 To: 9/12/2014 ☑ Initial ☐ Recertification

This Plan of Care is for (check): ☐ Home Health Visits ☑ Home Health Hours ☐ Personal Care Aide Hours

(1) Name of Beneficiary _____
First Name Middle Initial Last Name

(2) Permanent Address: 225 58TH PL NE, Washington, DC. 20019

(3) Phone [redacted] (4) Date of Birth (5) Sex M

(6) SS# (7) Medicare # (8) Medicaid #

(9) Contact Information for Next of Kin/Responsible Party (Indicate N/A if applicable):
ROSEMARY OGBENA
First Name Middle Initial Last Name

(10) Permanent Address

(11) Phone (202) 445-7786

(12) Describe the home environment and patient's support system (family and community resources):

Client Mr. home environment is clean, well arranged, safe and meets his needs

Name of Medicaid Beneficiary: S

Medicaid ID:

(13) Diagnosis(es) causing patient's disability(ies) and other pertinent diagnoses or surgical procedures:

Schizophrenia-295.9; Hypertension-401.9; MOOD DISORDER-296.83; High Cholesterol-445.0; -; -; -; -;

(14) FUNCTIONAL LIMITATIONS:

- [x] Bathing
- [x] Toileting
- [x] Dressing
- [ ] Eating
- [ ] Getting in and out of bed
- [x] Taking medication prescribed for self administration
- [ ] Other (specify)

ACTIVITIES PERMITTED:

- [ ] Bedrest
- [ ] Complete Bedrest
- [ ] BRP
- [x] Up As Tolerated
- [ ] Transfer Bed/Chair
- [ ] Toilet Independently
- [ ] Transfer Bed/Chair
- [x] Toilet with assistance
- [ ] Other (specify)
- [ ] Crutches
- [x] Cane
- [ ] Wheelchair
- [ ] Walker
- [ ] No restrictions

(15) Allergies: [ ] Yes, please explain [x] No

(16) Medication(s) (dose, route, frequency):

MEDICATIONS Managed by VA Nurse

(17) Skilled Nursing Service(s) Ordered (Specify amount/frequency/duration. If none, state none):

RN visit every month and as needed for a period 6 months for assessment of all systems and supervision of Home Health Aides.
Call MD for BP>160/90<90/60, pulse>100<60, Resp>24<14, Temp>100.5<96.6
If BS>250 client /Family/nurse to administer insulin as ordered, or if <60 give any juice available and call MD.
Instruct client on safety measures, fall precautions and emergency protocol.
All T&N staff/family/client to initiate 911 for any life threatening emergency and protocol

(18) Personal Care Aide/Home Health Aide Services Ordered (Specify amount/frequency/duration. If none, state none):

8hrs daily X 7 days a week for 6 months

Name of Medicaid Beneficiary:

Medicaid ID: 96

(19) Does the patient have a 24-hour management plan? (i.e. a plan of care of home health services/personal care aide services are not in the home)

☑ Yes, please explain ☐ No, RN documents recommendations

Client has Ms. Rosemary Ogbana who is his main support system. Rosemary will be available to assist in ADLs when PCA services are not available. Client has a phone to call in case of emergency.

(20) Nutritional Requirements:

☑ Yes, a specific diet is required. Explain below ☐ No, Indicate 'None' below

SLow salt diet, Low fat

(21) Safety Measures:

- ☑ Use of assistant device when ambulating
- ☑ Clear pathways of all obstructions
- ☑ Support during transfer and lifting
- ☐ No smoking or open flames in vicinity of oxygen
- ☐ Keep hard candy on patient at all times
- ☐ Wash hands before and after wound care
- ☐ Seizure precautions
- ☑ Coumadin precautions
- ☑ Client cannot be left unattended
- ☐ Keep side rails up at all times
- ☐ Other (Specify)

(22) Mental Status:

- ☑ Oriented
- ☐ Disoriented
- ☐ Comatose
- ☐ Lethargic
- ☑ Forgetful
- ☐ Agitated
- ☐ Depressed
- ☐ Other (specify)

(23) Goals

Patient will be maintained in a safe and comfortable environment with PCA services.

Patient /Caregiver(s) will be knowledgeable and competent in all aspects of:

- ☑ dietary regimen
- ☑ disease process
- ☐ Insulin preparation and administration
- ☐ Foley/suprapubic/condom catheter care and management
- ☑ medication regimen
- ☐ diabetic regimen
- ☐ wound care performance and management
- ☐ use of glucometer
- ☐ coudmadin/O2/seizure precautions
- ☐ NG G-Tube care and management

Patient will achieve maximum level of functioning in 26 weeks. Caregiver(s) will demonstr competency in patient care in 4 weeks.

(24)HHA/PCA Goals:

Client will be free from falls and injury. Client will adhere to medication and dietary regimen. Client will be discharged when goals are met.

Name of Medicaid Beneficiary:

Medicaid ID:

(25) Prognosis: ☐ Poor ☐ Guarded ☑ Fair ☐ Good ☐ Excellent

(26) Rehab Potential: ☐ Poor ☐ Guarded ☑ Fair ☐ Good ☐ Excellent

(27) Discharge Plans: Patient will be discharged to care of self/caregiver(s)/MD when:

☑ Patient needs skilled care and goals are met.

☐ Patient is referred to outpatient services.

☑ Patient/family members are able to provide care.

☐ Other (Specify)

Contact information for RN completing form:

(28) Name of RN: Velma Oberg

Practitioner approving Plan of Care:

(29) Name of Physician/Nurse Practitioner: IVAN MONSERRATE, MD

(30) Address 50 IRVING ST NW, WASHINGTON, DC 20422

(31) Phone (202) 745-8377 (32) Fax (202) 745-2209

(33) Physician/Nurse Practitioner Signature: [signature] (34) Date: 9.25.13

The practitioner must sign the form within 30 days of its development

Government of the District of Columbia
Department of Health Care Finance
Division of Long-Term Care

Plan of Care for Medicaid Personal Care Aide (PCA), Home Health Aide and/or Skilled Nursing Services

To be completed by the Licensed Home Health Agency (DC Medicaid Provider). Please print clearly and complete all sections. If you have questions about this form, please call DHCF at (202) 724-4282.

Name Of Home Health Agency: T & N RELIABLE NURSING CARE, LLC

Address: 3500 18th ST NE , Washington, DC, 20018-

Phone (202) 529-6510 Fax (202) 529-6570

Signature of RN completing form: Vina Olmpr Date: 9 24 13

Start of Care date: 5/21/2011

Plan of Care Certification Period: From: 11/21/2013 To: 5/20/2014 ☐ Initial ☑ Recertification

This Plan of Care is for (check): ☐ Home Health Visits ☐ Home Health Hours ☑ Personal Care Aide Hours

(1) Name of Beneficiary [redacted]
First Name Middle Initial Last Name

(2) Permanent Address: 229 60TH PL NE, WASHINGTON, DC 20019

(3) Phone [redacted] (4) Date of Birth [redacted]7 (5) Sex F

(6) SS# [redacted] (7) Medicare # [redacted] (8) Medicaid # [redacted]03

(9) Contact Information for Next of Kin/Responsible Party (indicate N/A if applicable):

[redacted]ed
First Name Middle Initial Last Name

(10) Permanent Address [redacted]

(11) Phone (202) 390-7509

(12) Describe the home environment and patient's support system (family and community resources):

Patient lives with others in a group home. Home is adequately furnished, clean, safe and meets her needs. She has two children who visit her regularly.

Name of Medicaid Beneficiary: Jennings

Medicaid ID: 70891203

(13) Diagnosis(es) causing patient's disability(ies) and other pertinent diagnoses or surgical procedures:

Generalized Weakness-728.87; Confusion-298.2; Hypertension-401.9; Hypercholesterolemia-272.0; Constipation-564.00; Acid Reflux-530.81; ; -;

(14) FUNCTIONAL LIMITATIONS:

- ☐ Bathing
- ☐ Toileting
- ☑ Dressing
- ☐ Eating
- ☐ Getting in and out of bed
- ☑ Taking medication prescribed for self administration
- ☐ Other (specify)

ACTIVITIES PERMITTED:

- ☐ Bedrest
- ☐ Complete Bedrest
- ☐ BRP
- ☑ Up As Tolerated
- ☐ Transfer Bed/Chair
- ☑ Toilet Independently
- ☐ Transfer Bed/Chair
- ☐ Toilet with assistance
- ☐ Other (specify)
- ☐ Crutches
- ☑ Cane
- ☐ Wheelchair
- ☑ Walker
- ☐ No restrictions

(15) Allergies: ☐ Yes, please explain ☑ No

(16) Medication(s) (dose, route, frequency):

Lactulose	10gm/15ml	by mouth	daily
Senna	8.6/50mg (1tab)	by mouth	daily
Amlodipine	5 MG (1tab)	by mouth	daily
Lovastatin	20MG (1tab)	BY MOUTH	nightly
Aggrenox	200-25mg (1tab)	by mouth	twice daily
Famotidine	20mg (1tab)	by mouth	daily
LISINOPRIL	40 MG (1tab)	by mouth	daily

(17) Skilled Nursing Service(s) Ordered (Specify amount/frequency/duration. If none, state none):

RN visit every month month and as needed for a period of 6 months for assessment of all systems and supervision of Home Health Aides.
Call MD for BP>160/90<90/60, pulse>100<60, Resp>24<14, Temp>100.5<96.5
If BS>250 client /Family/nurse to administer insulin as ordered, or if <60 give any juice available and call MD.
Instruct client on safety measures, fall precautions and emergency protocol.
All T&N staff/family/client to initiate 911 for any life threatening emergency and protocol

(18) Personal Care Aide/Home Health Aide Services Ordered (Specify amount/frequency/duration. If none, state none):

12hrs daily X 7 days a week for 6 months

Name of Medicaid Beneficiary: nga

Medicaid ID:

(19) Does the patient have a 24-hour management plan? (i.e. a plan of care of home health services/personal care aide services are not in the home)

☑ Yes, please explain ☐ No, RN documents recommendations

Patient lives in a group home with others and it is staffed for 24hrs a day.

(20) Nutritional Requirements:

☑ Yes, a specific diet is required. Explain below ☐ No, Indicate 'None' below

Low salt Diet, low fat diet

(21) Safety Measures:

☑ Use of assistant device when ambulating
☑ Clear pathways of all obstructions
☐ Support during transfer and lifting
☐ No smoking or open flames in vicinity of oxygen
☐ Keep hard candy on patient at all times
☐ Wash hands before and after wound care
☐ Seizure precautions
☐ Coumadin precautions
☐ Client cannot be left unattended
☐ Keep side rails up at all times
☐ Other (Specify)

(22) Mental Status:

☐ Oriented ☐ Comatose ☐ Forgetful ☐ Depressed
☑ Disoriented ☐ Lethargic ☐ Agitated ☑ Other (specify) confused

(23) Goals

Patient will be maintained in a safe and comfortable environment with PCA services.
Patient /Caregiver(s) will be knowledgeable and competent in all aspects of:

☑ dietary regimen ☑ medication regimen ☐ wound care performance and management
☑ disease process ☐ diabetic regimen ☐ use of glucometer
☐ insulin preparation and administration ☐ coudmadin/O2/seizure precautions
☐ Foley/superpubic/condom catheter care and management ☐ NG G-Tube care and management

Patient will achieve maximum level of functioning in 26 weeks. Caregiver(s) will demonstr
competency in patient care in 4 weeks.

(24)HHA/PCA Goals:

Client will be free from falls and injury. Client will adhere to medication and dietary regimen. Client will be discharged when goals are met.

Name of Medicaid Beneficiary:

Medicaid ID:

(25) Prognosis:	☐ Poor	☐ Guarded	☑ Fair	☐ Good	☐ Excellent
(26) Rehab Potential:	☐ Poor	☐ Guarded	☑ Fair	☐ Good	☐ Excellent

(27) Discharge Plans: Patient will be discharged to care of self/caregiver(s)/MD when:

- ☑ Patient needs skilled care and goals are met.
- ☐ Patient is referred to outpatient services.
- ☑ Patient/family members are able to provide care.
- ☐ Other (Specify)

Contact information for RN completing form:

(28) Name of RN: Vera Oberg

Practitioner approving Plan of Care:

(29) Name of Physician/Nurse Practitioner: Obisesan, MD

(30) Address: Howard University Hospital, Washington, DC

(31) Phone: (202) 865-3261 (32) Fax: (202) 865-3833

(33) Physician/Nurse Practitioner Signature: _____ (34) Date: 9/26/13

The practitioner must sign the form within 30 days of its development

KBC

Government of the District of Columbia
Department of Health Care Finance
Division of Long-Term Care

DHCF

Plan of Care for Medicaid Personal Care Aide (PCA), Home Health Aide and/or Skilled Nursing Services

To be completed by the Licensed Home Health Agency (DC Medicaid Provider). Please print clearly and complete all sections. If you have any questions about this form, please call DHCF at (202) 724-4282.

Name of Home Health Care Agency KBC HOME HEALTH CARE **Prov. No.** 036304400

Address 7506 GEORGIA AVENUE, NW WASHINGTON DC 20012 1608

Phone 202-291-6973 **Fax** 202-291-7018 **NPI** 1376694869

Signature of RN Completing form: for Regina A. RN **Date:** 9/26/13

Start of Care Date: 10/01/2011

Plan of Care Certification Period: **From:** 10/01/2013 **To:** 04/01/2014 ☐ Initial ☒ Recertification

This Plan of Care is for (check): ☐ Home Health Visits ☐ Home Health Hours ☒ Personal Care Aide Hours

(1) Name of Beneficiary:

(2) Permanent Address: 225 56TH PLACE NE , WASHINGTON, DC 20019

(3) Phone: **(4) Date of Birth:** 10/06/1949 **(5) Sex:** M

(6) SS # **(7) Medicare #** **(8) Medicaid** ----

(9) Contact Information for Next of Kin / Responsible Party (Indicate N/A if applicable)

ROSMARY Relation: CM

(10) Permanent Address , ,

(11) Phone:

(12) Describe the home environment and the patient's support system (family and community)

Patient lives in a group home which is maintained without safety hazard. Client is forgetful and has difficulty ambulating and performing his ADL's. He is at risk for self neglect so he needs PCA assistance with his ADL's/personal care. .

Name of Medicaid Beneficiary: M...
Medicaid ID:

(13) Diagnosis(es) causing the patient's disability(ies) and other pertinent diagnosis or surgical procedures

Diagnosis: 4019 HYPERTENSION NOS, 29592 SCHIZOPHRENIA NOS-CHR

(14) Functional Limitations:

Ambulation, Dyspnea With Minimal Exertion

Activities Permitted:

Up As Tolerated, Cane

(15) Allergies: ☐ Yes, please explain ☒ No.

NKDA

(16) Medication(s) (dose, route, and frequency):

~~AXID~~	~~150MG~~	~~EVERY DAY~~	~~BY MOUTH~~
Start 10/01/2011			
ABILIFY	20MG	DAILY	BY MOUTH
Start 10/01/2011			
HYDROCHLOROTHIAZIDE	25MG	DAILY	BY MOUTH
Start 10/01/2011			
ASPIRIN 81 MG	1 TAB.	EVERY DAY	BY MOUTH
Start 10/01/2011			
CALCIUM + VITAMIN D	500MG/200U	2X DAY	BY MOUTH
Start 10/01/2011			

D/C

1. Omeprazole 20mg daily
2. Simvastatin 10 mg QHS
3. Benzotropin 0.5 mg QHS

(17) Skilled Nursing Service(s) Ordered (Specify amount/frequency/duration. If none, state none.)
Wound Care Assessment: include stages of tissue destruction, location, size, drainage and depth of impaired skin integrity

SN: 1-2x month x 6 months and PRN . Assess clinical status, vital signs and response to medications, review diet and instruct on medications, assess medication and diet compliance, instruct and supervise personal care aide to assist client with personal care and ADL's.

PCA: 8hours daily x 7days x 6 months to assist with personal care and ADL's: complete bath, care of hair/nails, oral hygiene, foot care, assist w/ dressing/grooming, make bed/change linens. Assist with feeding, encourage fluids, change pt's position as needed, remind pt to take medications, supervise pt, straighten pt's room. PCA may accompany to MD appts, Household Activities: Light laundry, grocery shopping, meal preparation, light housekeeping.

MSW: 1-2 x m x 6 months prn to link to community resources and long term planning.

(18) Personal Care Aide/Home Health Aide Services Ordered (Specify amount/frequency/duration. If none, state none.)

8hours daily x 7days x 6 months to assist with personal care and ADL's: complete bath, care of hair/nails, oral hygiene, foot care, assist w/ dressing/grooming, make bed/change linens. Assist with feeding, encourage fluids, change pt's position as needed, remind pt to take medications, supervise pt, straighten pt's room. PCA may accompany to MD appts, Household Activities: Light laundry, grocery shopping, meal preparation, light housekeeping.

(19) Does the patient have a 24-Hour management plan? (i.e., a plan for care when home health services/personal care aide) services are not in the home)

☒ Yes, please explain ☐ No. RN documents recommendations

Staff, patient and caregivers have been instructed to call 911 and family member, i
case of an emergency

Name of Medicaid Beneficiary:

Medicaid ID

(27) Discharge Plans

Patient will be discharged to care of self/caregivers(s)/MD when:

- ☐ Patient needs skilled care and goals are met
- ☐ Patient is referred to outpatient services
- ☒ Patient/family members are able to provide care.

Other:

Contact Information for the RN completing form:

(28) Name of RN:

REGINA ANYIKENG

Practitioner approving Plan of Care:

(29) Name of Physician/Nurse Practitioner:

CAITLIN CROWTHER LIC: NPI: 15586522292

(30) Address WASH DC VA MEDICAL CENTER, NW, WASHINGTON DC 20422

(31) Phone 202-745-8445 **(32) Fax** 202-518-4635

(33) Physician/Nurse Practitioner Signature: X [signature] **(34) Date:** 10/4/13

The practitioner must sign the form within 30 days of its development

For Division of Long-Term Care use only

Approved for _____ **( ) Disapproved**

Approval Period _____

Doris Bean

Government of the District of Columbia
Department of Health Care Finance
Division of Long-Term Care

DHCF

Plan of Care for Medicaid Personal Care Aide (PCA), Home Health Aide and/or Skilled Nursing Services

To be completed by the Licensed Home Health Agency (DC Medicaid Provider). Please print clearly and complete all sections. If you have questions about this form, please call DHCF at (202) 724-4282.

Name Of Home Health Agency: T & N RELIABLE NURSING CARE, LLC

Address: 3500 18th ST NE , Washington, DC, 20018-

Phone (202) 529-6510 **Fax** (202) 529-6570

Signature of RN completing form: [signature] RN **Date:** 6/21/13

Start of Care date: 12/22/2008

Plan of Care Certification Period: From: 9/7/2013 **To:** 3/8/2014 ☐ Initial ☑ Recertification

This Plan of Care is for (check): ☐ Home Health Visits ☐ Home Health Hours ☑ Personal Care Aide Hours

(1) Name of Beneficiary

First Name Middle Initial Last Name

(2) Permanent Address: 225 56TH PL.NE, Washington, DC 20019

(3) Phone (**(4) Date of Birth** **(5) Sex** F

(6) SS# **(7) Medicare #** **(8) Medicaid #**

(9) Contact information for Next of Kin/Responsible Party (indicate N/A if applicable):

ROSEMARY OGBENNA

First Name Middle Initial Last Name

(10) Permanent Address , ,

(11) Phone (202) 445-7706

(12) Describe the home environment and patient's support system (family and community resources):

Patient lives in a group home that is staffed at all times. Home is well maintained and meets his needs.

Name of Medicaid Beneficiary: :AN

Medicaid ID: 703

(13) Diagnosis(es) causing patient's disability(les) and other pertinent diagnoses or surgical procedures:

Schizophrenia-295.9; Bipolar Disorder-296.8; -; -; -; -; ; -;

(14) FUNCTIONAL LIMITATIONS:

- [x] Bathing
- [ ] Toileting
- [x] Dressing
- [ ] Eating
- [ ] Getting in and out of bed
- [x] Taking medication prescribed for self administration
- [ ] Other (specify)

ACTIVITIES PERMITTED:

- [ ] Bedrest
- [ ] Complete Bedrest
- [ ] BRP
- [x] Up As Tolerated
- [ ] Transfer Bed/Chair
- [x] Toilet Independently
- [ ] Transfer Bed/Chair
- [ ] Toilet with assistance
- [ ] Other (specify)
- [ ] Crutches
- [ ] Cane
- [ ] Wheelchair
- [ ] Walker
- [ ] No restrictions

(15) Allergies: [x] Yes, please explain [ ] No

Seasonal

(16) Medication(s) (dose, route, frequency):

Ducosate sodium	200mg	by mouth	daily	
Abilify	15mg	by mouth	daily	
Diphenhydramine	25 MG	by mouth	at bedtim	
Trazadone	50 MG	by mouth	at bedtim	

(17) Skilled Nursing Service(s) Ordered (Specify amount/frequency/duration. If none, state none):

RN visit every month and as needed for a period of 6 months for assessment of all systems and supervision of lome Health Aides.
Call MD for BP>160/90<90/60, pulse>100<60, Resp>24<14, Temp>100.5<96.5
If BS>250 client /Family/nurse to administer insulin as ordered, or if <60 give any juice available and call MD.
Instruct client on safety measures, fall precautions and emergency protocol.
All T&N staff/family/client to innitiate 911 for any life threatening emergency and protocol

(18) Personal Care Aide/Home Health Aide Services Ordered (Specify amount/frequency/duration. If non , state none):

8hrs daily X 7 days a week for 6 months.

address herself

Name of Medicaid Beneficiary:

Medicaid ID: [redacted]0

(19) Does the patient have a 24-hour management plan? (i.e. a plan of care of home health services/personal care aide services are not in the home)

☑ Yes, please explain ☐ No, RN documents recommendations

Patient lives in a group home that is staffed at all times.

(20) Nutritional Requirements:

☑ Yes, a specific diet is required. Explain below ☐ No Indicate 'None' below

low sodium

(21) Safety Measures:

- ☑ Use of assistant device when ambulating
- ☑ Clear pathways of all obstructions
- ☐ Support during transfer and lifting
- ☐ No smoking or open flames in vicinity of oxygen
- ☐ Keep hard candy on patient at all times
- ☐ Wash hands before and after wound care
- ☐ Seizure precautions
- ☐ Coumadin precautions
- ☐ Client cannot be left unattended
- ☐ Keep side rails up at all times
- ☐ Other (Specify) Call 911 for life threatening emergenc

(22) Mental Status:

- ☑ Oriented
- ☐ Comatose
- ☑ Forgetful
- ☐ Depressed
- ☐ Disoriented
- ☐ Lethargic
- ☐ Agitated
- ☐ Other (specify)

(23) Goals

Patient will be maintained in a safe and comfortable environment with PCA services.

Patient /Caregiver(s) will be knowledgeable and competent in all aspects of:

- ☑ dietary regimen
- ☑ medication regimen
- ☐ wound care performance and management
- ☑ disease process
- ☑ diabetic regimen
- ☑ use of glucometer
- ☐ Insulin preparation and administration
- ☐ coudmadin/O2/seizure precautions
- ☐ Foley/suprepubic/condom catheter care and management
- ☐ NG G-Tube care and management

Patient will achieve maximum level of functioning in 26 weeks. Caregiver(s) will demonstr competency in patient care in 4 weeks.

(24)HHA/PCA Goals:

Client will be free from falls and injury. Client will adhere to medication and dietary regimen. Client will be discharge when goals are met.

Name of Medicaid Beneficiary:

Medicaid ID:

(25) Prognosis: ☐ Poor ☐ Guarded ☑ Fair ☐ Good ☐ Excellent

(26) Rehab Potential: ☐ Poor ☐ Guarded ☑ Fair ☐ Good ☐ Excellent

(27) Discharge Plans: Patient will be discharged to care of self/caregiver(s)/MD when:

☑ Patient needs skilled care and goals are met.

☐ Patient is referred to outpatient services.

☑ Patient/family members are able to provide care.

☐ Other (Specify)

Contact Information for RN completing form:

(28) Name of RN: VERA OBERG

Practitioner approving Plan of Care:

(29) Name of Physician/Nurse Practitioner: THOMAS OBISESAN, MD

(30) Address HOWARD UNIVERSITY HOSPITAL, WASHINGTON, DC 20060

(31) Phone (202) 865-3290 (32) Fax (202) 865-3776

(33) Physician/Nurse Practitioner Signature: (34) Date: 2/18/1

The practitioner must sign the form within 30 days of its development

Government of the District of Columbia
Department of Health Care Finance
Division of Long-Term Care

Plan of Care for Medicaid Personal Care Aide (PCA), Home Health Aide and/or Skilled Nursing Services

To be completed by the Licensed Home Health Agency (DC Medicaid Provider). Please print clearly and complete all sections. If you have questions about this form, please call DHCF at (202) 724-4282.

Name Of Home Health Agency: T & N RELIABLE NURSING CARE, LLC

Address: 3500 18th ST NE , Washington, DC, 20018-

Phone (202) 529-6510 **Fax** (202) 529-6570

Signature of RN completing form: Vera Chuyko **Date:** 9/24/13

Start of Care date: 11/12/2009

Plan of Care Certification Period: From: 11/13/2013 **To:** 5/12/2014 ☐ Initial ☑ Recertification

This Plan of Care is for (check): ☐ Home Health Visits ☐ Home Health Hours ☑ Personal Care Aide Hours

(1) Name of Beneficiary [redacted] A [redacted]
First Name Middle Initial Last Name

(2) Permanent Address: 4910 1ST STREET NW, Washington, DC 20011

(3) Phone **(4) Date of Birth** [redacted] **(5) Sex** M

(6) SS# [redacted] **(7) Medicare #** **(8) Medicaid #** [redacted]

(9) Contact information for Next of Kin/Responsible Party (Indicate N/A if applicable):

Rosemary
First Name Middle Initial Last Name

(10) Permanent Address

(11) Phone (202) 445-7786

(12) Describe the home environment and patient's support system (family and community resources):

Patient lives in a group home. Home environment is clean, safe, well arranged and meets his needs.

Name of Medicaid Beneficiary: MES

Medicaid #

(13) Diagnosis(es) causing patient's disability(ies) and other pertinent diagnoses or surgical procedures:

UNSTEADY GAIT-781.3; Hypertension-401.9; Hx of stroke-v17.1; Back Pain-724.5; DM II-250.0; hyperlipidemia-272.4; ; -;

(14) FUNCTIONAL LIMITATIONS:

- ☐ Bathing
- ☐ Toileting
- ☑ Dressing
- ☐ Eating
- ☐ Getting in and out of bed
- ☑ Taking medication prescribed for self administration
- ☐ Other (specify)

ACTIVITIES PERMITTED:

- ☐ Bedrest
- ☐ Complete Bedrest.
- ☐ BRP
- ☑ Up As Tolerated
- ☐ Transfer Bed/Chair
- ☑ Toilet Independently
- ☐ Transfer Bed/Chair
- ☐ Toilet with assistance
- ☐ Other (specify) patient uses a cane as needed
- ☐ Crutches
- ☑ Cane
- ☐ Wheelchair
- ☐ Walker
- ☐ No restrictions

(15) Allergies: ☐ Yes, please explain ☑ No

(16) Medication(s) (dose, route, frequency):

Docusate	50mg (1tab)	by mouth	twice daily
Ferrous gluconate	1tab	by mouth	daily
metroprolol	25mg (1&1/2tabs)	by mouth	daily
Nifedipine	90mg (2tabs)	by mouth	daily
Dialyvite	1tab	by mouth	daily
vitamin B1 (Thiamin)	100mg (1tab)	by mouth	daily
LISINOPRIL	20 MG (1&1/2tabs)	by mouth	daily
Simvastatin	40mg (1&1/2tabs)	by mouth	daily
Tantus Insulin	9units	subcut	every morning
Dextrose	40% oralgel (1tab)	Oral	daily as needed
Clonidine	0.2mg (patch)	dermal	Every Friday

(17) Skilled Nursing Service(s) Ordered (Specify amount/frequency/duration. If none, state none):

RN visit every month and as needed for a period of 6 months for assessment of all systems and supervision of Home Health Aides.
Call MD for BP>160/90<90/60, pulse>100<60, Resp>24<14, Temp>100.5<96.5
If BS>250 client /Family/nurse to administer insulin as ordered, or if <60 give any juice available and call MD.
Instruct client on safety measures, fall precautions and emergency protocol.
All T&N staff/family/client to initiate 911 for any life threatening emergency and protocol

(18) Personal Care Aide/Home Health Aide Services Ordered (Specify amount/frequency/duration. If none, state none):

8hrs daily X 7 days a week for 8 months

Name of Medicaid Beneficiary:

Medicaid ID:

(18) Does the patient have a 24-hour management plan? (i.e. a plan of care of home health services/personal care aide services are not in the home)

☑ Yes, please explain ☐ No, RN documents recommendations

Patient lives in a group home and it is staffed 24hrs a day. There is a phone in the home to call in case of emergency.

(20) Nutritional Requirements:

☑ Yes, a specific diet is required. Explain below ☐ No, Indicate 'None' below

No conc sweets, Low sodium diet, low fat

(21) Safety Measures:

- ☑ Use of assistant device when ambulating
- ☑ Clear pathways of all obstructions
- ☐ Support during transfer and lifting
- ☐ No smoking or open flames in vicinity of oxygen
- ☑ Keep hard candy on patient at all times
- ☐ Wash hands before and after wound care
- ☐ Seizure precautions
- ☐ Coumadin precautions
- ☐ Client cannot be left unattended
- ☐ Keep side rails up at all times
- ☐ Other (Specify)

(22) Mental Status:

- ☑ Oriented
- ☐ Disoriented
- ☐ Comatose
- ☐ Lethargic
- ☐ Forgetful
- ☐ Agitated
- ☐ Depressed
- ☐ Other (specify)

(23) Goals

Patient will be maintained in a safe and comfortable environment with PCA services.

Patient /Caregiver(s) will be knowledgeable and competent in all aspects of:

- ☑ dietary regimen
- ☑ disease process
- ☑ Insulin preparation and administration
- ☐ Foley/superpubic/condom catheter care and management
- ☑ medication regimen
- ☑ diabetic regimen
- ☐ wound care performance and management
- ☑ use of glucometer
- ☐ coudmadin/O2/seizure precautions
- ☐ NG G-Tube care and management

Patient will achieve maximum level of functioning in competency in patient care in 4 weeks. 26 weeks. Caregiver(s) will demonstr

(24)HHA/PCA Goals:

Client will be free from falls and injury. Client will adhere to medication and dietary regimen. Client will be discharged when goals are met.

Nurse teaches patient and then he demonstrates indep. Good appetite, mood

Name of Medicaid Beneficiary: F

Medicaid ID:

(25) Prognosis:	☐ Poor	☐ Guarded	☐ Fair	☑ Good	☐ Excellent
(26) Rehab Potential:	☐ Poor	☐ Guarded	☐ Fair	☑ Good	☐ Excellent

(27) Discharge Plans: Patient will be discharged to care of self/caregiver(s)/MD when:

- ☑ Patient needs skilled care and goals are met.
- ☐ Patient is referred to outpatient services.
- ☑ Patient/family members are able to provide care.
- ☐ Other (Specify)

Contact Information for RN completing form:

(28) Name of RN: VERA OBERG

Practitioner approving Plan of Care:

(29) Name of Physician/Nurse Practitioner: CHANG YONMEE, MD

(30) Address 50 IRVING ST NW, WASHINGTON, DC 20422

(31) Phone (202) 745-8000 (32) Fax (202) 518-4880

(33) Physician/Nurse Practitioner Signature: _____ (34) Date: 10, 11, 13

The practitioner must sign the form within 30 days of its development

Government of the District of Columbia
Department of Health Care Finance
Division of Long-Term Care

Plan of Care for Medicaid Personal Care Aide (PCA), Home Health Aide and/or Skilled Nursing Services

To be completed by the Licensed Home Health Agency (DC Medicaid Provider). Please print clearly and complete all sections. If you have questions about this form, please call DHCF at (202) 724-4282.

Name Of Home Health Agency: T & N RELIABLE NURSING CARE, LLC

Address: 3500 18th ST NE . Washington, DC, 20018-

Phone (202) 529-6510 Fax (202) 529-6570

Signature of RN completing form: Vina Okuy RN Date: 9/13/13

Start of Care date: 9/13/2013

Plan of Care Certification Period: From: 9/13/2013 To: 3/12/2014 ☑ Initial ☐ Recertification

This Plan of Care is for (check): ☐ Home Health Visits ☑ Home Health Hours ☐ Personal Care Aide Hours

(1) Name of Beneficiary

First Name Middle Initial Last Name

(2) Permanent Address: 223 55TH PL NE, Washington, DC 20019

(3) Phone (4) Date of Birth (5) Sex M

(6) SS# (7) Medicare # (8) Medicaid #

(9) Contact information for Next of Kin/Responsible Party (Indicate N/A if applicable):

ROSEMARY OGBENA
First Name Middle Initial Last Name

(10) Permanent Address ,,

(11) Phone (202) 445-7786

(12) Describe the home environment and patient's support system (family and community resources):

Client receives support from Rosemary Ogbena. Her home environment is clean, well arranged, safe and meets her needs.

Name of Medicaid Beneficiary:

Medicaid ID:

(13) Diagnosis(es) causing patient's disability(ies) and other pertinent diagnoses or surgical procedures:

Paranoid schizophrenia-295.30; Hypertension-401.9; GERD-530.81; hyperlipidemia-272.4; Constipation-564.00;

(14) FUNCTIONAL LIMITATIONS:

- ☐ Bathing
- ☐ Toileting
- ☐ Dressing
- ☐ Eating
- ☐ Getting in and out of bed
- ☑ Taking medication prescribed for self administration
- ☐ Other (specify)

ACTIVITIES PERMITTED:

- ☐ Bedrest
- ☐ Complete Bedrest
- ☐ BRP
- ☑ Up As Tolerated
- ☐ Transfer Bed/Chair
- ☑ Toilet independently
- ☐ Transfer Bed/Chair
- ☐ Toilet with assistance
- ☐ Other (specify)
- ☐ Crutches
- ☐ Cane
- ☐ Wheelchair
- ☐ Walker
- ☐ No restrictions

(15) Allergies: ☐ Yes, please explain ☑ No

(16) Medication(s) (dose, route, frequency):

Aspirin	81mg (1tab)	by mouth	daily
Omeprazole	20 MG (1tab)	by mouth	daily
Amlodipine besylate	10mg (1tab)	by mouth	daily
Rosuvastatin ca	10mg(1&1/2tabs)	by mouth	at bedtime
Docusate NA	100 MG (1cap)	by mouth	daily
Htcz/Lisinopril	12.5mg/20mg (1tab	by mouth	daily

(17) Skilled Nursing Service(s) Ordered (Specify amount/frequency/duration. If none, state none):

RN visit every month and as needed for a period 6 months for assessment of all systems and supervision of Home Health Aides.
Call MD for BP>160/90<90/60, pulse>100<60, Resp>24<14, Temp>100.5<96.6
If BS>250 client /Family/nurse to administer insulin as ordered, or if <60 give any juice available and call MD.
Instruct client on safety measures, fall precautions and emergency protocol.
All T&N staff/family/client to initiate 911 for any life threatening emergency and protocol

(18) Personal Care Aide/Home Health Aide Services Ordered (Specify amount/frequency/duration. If none, state none):

8hrs daily X 7 days a week for 6 months

Name of Medicaid Beneficiary:

Medicaid ID:

(19) Does the patient have a 24-hour management plan? (i.e. a plan of care of home health services/personal care aide services are not in the home)

☑ Yes, please explain ☐ No, RN documents recommendations

Patient has a family member. Ms. Rosemary Ogbena. She is his main support system and will be available to assist in his ADLs when PCA services are not available. Client has a phone to call in case of emergency.

(20) Nutritional Requirements:

☑ Yes, a specific diet is required. Explain below ☐ No. Indicate 'None' below

Low fat/cholesterol, low salt

(21) Safety Measures:

☐ Use of assistant device when ambulating
☐ Clear pathways of all obstructions
☐ Support during transfer and lifting
☐ No smoking or open flames in vicinity of oxygen
☐ Keep hard candy on patient at all times
☐ Wash hands before and after wound care
☐ Seizure precautions
☐ Coumadin precautions
☐ Client cannot be left unattended
☐ Keep side rails up at all times
☐ Other (Specify)

(22) Mental Status:

☑ Oriented ☐ Comatose ☐ Forgetful ☐ Depressed
☐ Disoriented ☐ Lethargic ☐ Agitated ☐ Other (specify) Encourage fluid intake

(23) Goals

Patient will be maintained in a safe and comfortable environment with PCA services.
Patient /Caregiver(s) will be knowledgeable and competent in all aspects of:

☑ dietary regimen ☑ medication regimen ☐ wound care performance and management
☑ disease process ☐ diabetic regimen ☐ use of glucometer
☐ Insulin preparation and administration ☐ coudmadin/O2/seizure precautions
☐ Foley/superpubic/condom catheter care and management ☐ NG G-Tube care and management

Patient will achieve maximum level of functioning in 26 weeks. Caregiver(s) will demonstr competency in patient care in 4 weeks.

(24)HHA/PCA Goals:

Client will be free from falls and injury. Client will adhere to medication and dietary regimen. Client will be discharged when goals are met.

Name of Medicaid Beneficiary: RONALD PATTERSON

Medicaid ID: 70144118

(25) Prognosis: ☐ Poor ☐ Guarded ☑ Fair ☐ Good ☐ Excellent

(26) Rehab Potential: ☐ Poor ☐ Guarded ☑ Fair ☐ Good ☐ Excellent

(27) Discharge Plans: Patient will be discharged to care of self/caregiver(s)/MD when:

☑ Patient needs skilled care and goals are met.

☐ Patient is referred to outpatient services.

☑ Patient/family members are able to provide care.

☐ Other (Specify)

Contact information for RN completing form:

(28) Name of RN: VERA OBERLE

Practitioner approving Plan of Care:

(29) Name of Physician/Nurse Practitioner: PERRI FLORA, NP

(30) Address 50 IRVING ST NW, WASHINGTON, DC 20422

(31) Phone (202) 745-8267 (32) Fax (202) 745-8611

(33) Physician/Nurse Practitioner Signature: Flora Perri NP (34) Date: 10,2,13

The practitioner must sign the form within 30 days of its development