Form CMS-485 HOME HEALTH CERTIFICATION AND PLAN OF CARE

Patient's HI Claim No.	Start of Care	Certification Period	Medical Record No.	Provider No.
5WM9TD9UG43	06/11/2025	06/11/2025 Through 08/09/2025	6653015	227027

Physician Name and Address	Patient	DOB
Christine A Will, MD Hawthorn Medical Associates 531 Faunce Corner Rd. North Dartmouth, MA 02747 (508) 996-3991 Fax (508) 961-2535	Brown, Ruth D 4 Anderson Way Apt E North Dartmouth, MA 02747	03/30/1937 **Sex** F

Directives In Place/Risk of Hospitalization	Provider Name and Address
Advance Care Plan Discussion - Discussion held, other - Full code Risk of Hospitalization History of falls (2 or more falls - or any fall with an injury - in the past 12 months) Multiple emergency department visits (2 or more) in the past 6 months Currently taking 5 or more medications Currently reports exhaustion Other Risk	Community Nurse Inc 62 Center Street Fairhaven, MA 02719 (508) 992-6278 Fax (508) 997-3091

11. Dx Code	Principal Diagnosis	Date
N39.0	Urinary tract infection, site not specified [ICD10]	6/11/2025 E

12. Dx Code	Surgical Procedure	Date
N/A		

13. Dx Code	Other Pertinent Diagnoses	Date
I10	Essential (primary) hypertension [ICD10]	6/11/2025 E
K59.00	Constipation, unspecified [ICD10]	6/11/2025 E
K76.89	Other specified diseases of liver [ICD10]	6/11/2025 E
M51.27	Other intervertebral disc displacement, lumbosacral region [ICD10]	6/11/2025 E
E03.9	Hypothyroidism, unspecified [ICD10]	6/11/2025 E
C18.9	Malignant neoplasm of colon, unspecified [ICD10]	6/11/2025 E
H54.7	Unspecified visual loss [ICD10]	6/11/2025 E
H91.93	Unspecified hearing loss, bilateral [ICD10]	6/11/2025 E
M19.90	Unspecified osteoarthritis, unspecified site [ICD10]	6/11/2025 E
Z87.440	Personal history of urinary (tract) infections [ICD10]	6/11/2025 E
Z91.81	History of falling [ICD10]	6/11/2025 E
Z79.01	Long term (current) use of anticoagulants [ICD10]	6/11/2025 E

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

amLODIPine 2.5 mg tablet 1 tablets oral once a day (N)
ascorbic acid 1000 mg tablet 1 tablets oral once a day (N)
carbidopa-levodopa 50 mg-200 mg tablet, extended release 1 tablets oral 3 times a day (N)
Eliquis 5 mg tablet 1 tablets oral 2 times a day (N)
gabapentin 100 mg capsule 1 cap(s) oral 2 times a day (N)
levothyroxine 25 mcg (0.025 mg) tablet 1 tablets oral once a day (N)
lisinopril 20 mg tablet 1 tablets oral once a day (N)
magnesium oxide 250 mg tablet 1 tablets oral once a day (N)
nitrofurantoin macrocrystals 100 mg capsule 1 cap(s) oral 2 times a day x 7d (N)
omeprazole 20 mg delayed release tablet 1 tablets oral once a day (N)
Vitamin D3 25 mcg capsule 1 cap(s) oral once a day (N)

14. DME and Supplies	15. Safety Measures
Rolling walker, grab bars, shower chair, handheld shower, reacher	Fall precautions, Hand railings, Lifeline, No ambulation w/o assist, Universal precautions, Use of safety devices in bathroom

16. Nutritional Req.	17. Allergies
Cardiac	NKA

18A. Functional Limitations	18B. Activities Permitted
Ambulation, Bowel/Bladder (Incontinence), Dyspnea w/minimal exertion, Endurance, Pain	Up as tolerated, Walker

19. Mental Status	20. Prognosis
Oriented, Forgetful	Good

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

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SN: 1x/wk x 9 wks, PRNx4 Complications/Med Changes
Patient Risk for Emergency Room use or Hospitalization is assessed to be: Moderate and will be addressed with measures focusing on: Cardiopulmonary assess & vital signs, energy conservation teach, safety assess & fall prevent teach, med management and teaching, nutrition/hydration, medication manage & teachi, GU assess, UTI prevention & incontinence manage teach. Skilled Observation & Assessment of Cardiovascular Status, Dyspnea, Edema, GU Status, Integument Status, Medication Use/Effect, Nutrition/Hydration, Respiratory Status, S/SX Pressure/Breakdown, S/SX UTI, Safety. Assess oxygen saturation as needed and report to physician if less than 88%. Assess vital signs and report the following to the physician: Temperature over 101.5, Systolic Blood Pressure over 160, or less than 90, Diastolic Blood Pressure over 90, Heart Rate less than 50, or greater than 120, Respirations greater than 26. C- Assess patient pain. T-Teach Interventions to prevent pressure ulcers. T-Teach patient/caregiver falls risk associated with medical conditions and medications. T-Teach patient/caregiver how and when to report medication issues. Teach- Interventions to monitor and mitigate pain. Teach Energy Conservation With Activity, How to Access Emergency Aid, Management of Urinary Incontinence, Perineal Hygiene, Rest & Comfort, S/SX Infection
PT: Start on 06/12/2025: 1x/wk x 1 wk, 1-2x/wk x 1 wk, 1x/wk x 7 wks, PRNx4 Change in Functional Stat
Assess oxygen saturation as needed and report to physician if less than 88%. Assess vital signs and report the following to the physician: Temperature over 101.5, Systolic Blood Pressure over 160, or less than 90, Diastolic Blood Pressure over 90, Heart Rate less than 50, or greater than 120, Respirations greater than 26. C- Assess patient pain. Fall Prevention Instruction. Instruction and Progression of HEP. Patient/Caregiver Education. Teach Functional Mobility. Transfer Training. Teach Activities to Enhance Endurance, Body Mechanics, Community Ambulation, Gait Training, Home Exercise Program, Home Safety, Pacing, Stair Training
HCA: Start on 06/22/2025: 1x/wk x 2 wks
Assist With Personal Care

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Patient Stated Personal Goal: Short Term Goal: Less sore within cert period. Patient Stated Personal Goal- Long Term Goal: Less stiff, walk more within cert period. Patient/CG will be able to teach back 3 signs/symptoms of urinary tract infection within 2 weeks within cert period. Patients Pain Will Be Controlled within cert period. Pt/Cg will verbalize understanding of pressure relief measures within cert period. PT/SO Verbalize Understanding Of Medication Program & Appropriate Action To Take If Adverse Side Effects Occur within cert period. Safety In Home within cert period. Stable CVP Status within cert period
PT Goals: Goal: Patient will be free from falls for 4 weeks within cert period. Patient Stated Personal Goal- Goal: " I want to be able to do for myself" within cert period. Patient will increase strength BLE by 1/2 grade proximally to improve functional mobility skills on all surfaces within cert period. Patient will amb 1 x 300 feet on even and uneven surfaces independently with rollator to allow access to community services within cert period. Patient will perform all functional transfers independently adhering to fall prevention techniques within cert period. Patient will improve activity tolerance to 15 minutes in standing to allow for completion of functional tasks within cert period. Patient will ascend/descend 12 + outdoor stairs with railing/ st cane and supervision to allow entrance to/egress from home within cert period. Patient will improve Tinetti score to 21/28 to demonstrate reduced fall risk with functional mobility within cert period. Patient will independently adhere to fall prevention/safety awareness techniques including walker management and appropriate body mechanics to reduce fall risk with mobility . within cert period
HCA Goals: Pt's ADL Status Will Be Maintained within cert period

SN: Rehab Potential is Good For the Above Goals
PT: Rehab Potential is Excellent For the Above Goals
HCA: Rehab Potential is Good For the Above Goals
Discharge Plan: Discharge to Self Care With Family Community Support

Clinical Summary SN: SOC: 88-year-old widowed female presented to St. Luke's Hospital on June 10, 2025, after sustaining a fall at home. The patient had a mechanical trip and fall, reporting left-sided rib pain due to hitting her side on a chest of drawers. No loss of consciousness noted. CT cervical spine, chest, abdomen, and pelvis negative for any acute change.

Primary DX: fall, UTI

PMH: Arthritis, benign liver cyst, colon cancer, constipation, diverticulitis, GERD, hypothyroidism, dementia, history of multiple falls in the last year, history of multiple urinary tract infections, partial resection of colon 2020, laparoscopic ileocolectomy for colon lipoma, thyroid nodule removal 2012, forgetfulness.

COGNITION: Alert and oriented times 3, forgetful.

CARDIOVASCULAR: Heart rate regularly irregular, blood pressure orthostatic down from 112/60 to 88/40. Patient denies dizziness, lightheadedness, and palpitations. 2+ pedal edema pitting, 1+ lower extremity from knees down to feet.

PULMONARY: Lung sounds clear, diminished, no cough. Observed shortness of breath with minimal exertion.

BORG: 0

MOBILITY/ADL's: Patient ambulatory about home with Rollator, requiring assist from sit to stand due to rigidity and weakness. Requiring assist with ADL's due to easy fatigue. Shortness of breath with minimal exertion.

SKIN: Skin to coccyx, buttocks, skin folds, hips, spine, heels, and feet intact.

PAIN: Denies Left-sided rib pain. Patient has some all-over achiness and soreness status post fall. Patient doesn't deny any headache.

GI/GU: Patient diagnosed with a UTI and started on antibiotic nitrofurantoin.

ENDOCRINE: Taking levothyroxine for hypothyroid.

DIET/NUTRITION: Cardiac.

WEIGHT/MEASUREMENTS: Unable to weigh due to unsteady balance.

SAFETY: High risk of fall due to history of falls related to orthostatic hypotension, unsteady gait, shortness of breath with minimal exertion, medical comorbidity, advanced age, and history of falls. Patient has life alert.

MEDS: All medications via pillbox managed by patient's son. All medications in home matching referral list from St. Anne's Hospital with clarifications made by PCP Dr. Will for current regimen as in home in pillboxes.

DEPRESSION: Patient denies any depression.

LIVING SITUATION: Patient lives in elder housing in Dartmouth on second story.

HOMEBOUND: Ambulatory household distances with rolling walker requiring frequent rest periods related to pain, unsteady gait, SOB with minimal exertion resulting in taxing effort related to cardiovascular, musculoskeletal and neurological changes attributable to fall secondary to Parkinson's, UTI

GOALS: (Short Term and Long Term): less stiff/sore, walk more

HEALTH LITERACY: Low.

EMERGENCY PREPAREDNESS PLAN: Shelter in place.

CODE STATUS/ADVANCED DIRECTIVES: Full code, no health care proxy available. Son will be reaching out to lawyer to get these documents.

COMMUNITY RESOURCES: Coastline Elder Services for PCA, Homemaking, Life Alert, and Meals on Wheels.

UPCOMING APPOINTMENTS: June 16, 2025, will be seen by Neurology.

REFERRALs:
PT
OT
SN

SKILL/REASON FOR HOME CARE: Cardiopulmonary assess & vital signs, energy conservation teach, safety assess & fall prevent teach, med management and teaching, nutrition/hydration, medication manage & teachi, GU assess, UTI prevention & incontinence manage teach

A list of local federal and state funded resources was provided. Red flag document reviewed. MD was informed and is in agreement with POC. The POC was reviewed with the patient who verbalizes understanding and agrees to participate.

PPE: universal precautions
PT: PT EVALUATION:

REASON FOR REFERRAL: Patient seen this date for skilled PT evaluation. Patient is an 88-year-old widowed female who sustained a fall at home on June 10, 2020. Patient presented to St. Luke's Hospital with reports of left-sided rib / hip pain which she hit on a chest of drawers during fall. No loss of consciousness noted. CAT scans of spine, chest, abdomen, and pelvis were negative for any acute changes. Patient reports she was turning around foot of bed where she keeps her hearing aides. Reports she had left rollator at the bedroom door

Primary diagnosis: Fall, UTI.

PMH: Arthritis, benign liver cyst, colon cancer, constipation, diverticulitis, GERD, hypothyroidism, dementia, history of multiple falls in the last year, history of multiple urinary tract infections, partial resection of the colon, 2020 laparoscopic ileocolectomy for colon, lipoma, thyroid nodule removed in 2012, forgetfulness.

Soc HX/PLOF: Patient lives alone in a second-floor elderly housing apartment with one flight of stairs encompassing 12+ stairs with bilateral railings to enter/exit home. Patient ambulated with rollator walker independently prior to hospitalization. Patient reports utilizing rollator x at least 1 year. States she was performing stairs amb with railing and st cane independently. Patient has weekly PCA assist.

CODE STATUS: Full code. No HCP noted.

COGNITION: Alert and oriented x3, although forgetful at times.

CURRENT LEVEL OF FUNCTION: Patient presents with decreased proximal strength BLE, decreased safety awareness, and decreased standing dynamic balance resulting in decreased functional mobility skills on all surfaces with increased fall risk.

BED MOBILITY: Patient declines bed mobility/transfers to/from bed this date as she sleeps in recliner. Patient states that bed is too high for her and she is more comfortable in the chair.

TRANSFERS: Patient performs sit-to-stand transfers from recliner, toilet, and kitchen chair with 1 CGA and verbal cues for hand placement and cues for safety regarding positioning of rollator walker.

GAIT: Patient ambulated with rollator 2 x 30 ft with decreased gait velocity, decreased gait tolerance, decreased step length/height, and decreased base of support. Patient amb with kyphosis posture and looking at floor throughout. Patient declined stair ambulation this date due to fatigue.

MMT: RLE hip 4-/5, knee 4/5, ankle 4/5;
LLE hip 4-/5, knee 4/5, ankle 4/5.

ROM: WFL BLE throughout.

SAFETY: MAHC 10 = 7 Tinetti score = 14 /28

SKILL/REASON FOR THERAPY SERVICES: Skilled PT is necessary to address decreased activity tolerance, increased fall risk, and decreased functional mobility skills in order to return to PLOF with reduced risk for falls and debility, as well as provide safety education and education on compensatory strategies for residual impairments.

HOMEBOUND: Patient is homebound secondary to increased fall risk and decreased mobility skills. Patient requires assist of one/device to leave home along with leaving home as a taxing effort.

ESTIMATED # VISITS: 6

POC REVIEW: POC reviewed with patient, who verbalized understanding. Consent form reviewed with patient. Patient verbalized understanding. This writer witnessed patient signing the consent form and it was scanned to office.

K. Manchester, PT, DPT

Nurse's Signature and Date of Verbal SOC	Case Manager	Date HHA Received Signed POT
Christine O'Donnell RN *E-Signature* 07/07/2025 @ 09:50 AM/Tara Danley RN 6/11/2025 @ 11:41 AM	Julie Wimberly RN	(Sent 7/8/2025)

Attending Physician's Signature and Date Signed

I certify that the patient had a F2F encounter on 06/10/2025 that was related to the primary reason for home health care and was conducted by an allowed practitioner. I certify/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. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan. 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. My signature indicates review and incorporation of this plan of care and supporting documentation into this patient□s medical record.

Signature**X** Date**X**

Christine A Will, MD

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