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.
100206789446	08/18/2023	06/08/2025 Through 08/06/2025	421010	140111

Physician Name and Address

Christine A Will, MD
535 Faunce Corner Rd
North Dartmouth, MA 02747
(508) 996-3991 Fax (508) 961-0928

Patient

Carvalho, Makaela
80 Francis Street
Acushnet, MA 02743

DOB

06/16/1994

Sex

F

Directives In Place/Risk of Hospitalization

Advance Care Plan Discussion - Discussion held, patient declined to provide ACP

Risk of Hospitalization

Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
Currently taking 5 or more medications
Other Risk

Provider Name and Address

Innovive Health of Massachusetts LLC
10 Cabot Rd Suite 201
Medford, MA 02155
(617) 623-3211
Fax (844) 546-7422

11. Dx Code	Principal Diagnosis	Date
F25.0	Schizoaffective disorder, bipolar type [ICD10]	8/3/2023 E

12. Dx Code	Surgical Procedure	Date
N/A		

13. Dx Code	Other Pertinent Diagnoses	Date
E11.9	Type 2 diabetes mellitus without complications [ICD10]	2/26/2023 E
F41.9	Anxiety disorder, unspecified [ICD10]	8/5/2022 E
J96.11	Chronic respiratory failure with hypoxia [ICD10]	7/25/2023 E
J44.9	Chronic obstructive pulmonary disease, unspecified [ICD10]	8/18/2023 O
G47.33	Obstructive sleep apnea (adult) (pediatric) [ICD10]	7/25/2023 E
D64.89	Other specified anemias [ICD10]	5/18/2020 O
E88.810	Metabolic syndrome [ICD10]	10/1/2023 O
Z87.01	Personal history of pneumonia (recurrent) [ICD10]	2/26/2023 E
Z79.899	Other long term (current) drug therapy [ICD10]	12/18/2020 O
Z91.81	History of falling [ICD10]	1/4/2021 O
R45.851	Suicidal ideations [ICD10]	9/15/2021 E
E66.9	Obesity, unspecified [ICD10]	9/15/2021 O
Z68.43	Body mass index (BMI) 50.0-59.9, adult [ICD10]	9/15/2021 O
R25.1	Tremor, unspecified [ICD10]	8/5/2022 E
G47.00	Insomnia, unspecified [ICD10]	8/5/2022 E

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

acarbose 25 milligram oral once a day pm w/meals for hypoglycemia
Prescribed By: Cardoza, Gabriella NP (Nurse Practitioner), 4/2/2024

Albuterol 2 puffs inhalation every 4 hours PRN Wheezing (90 mcg)
Prescribed By: Will, Christine A MD (Internal Medicine), 4/7/2025

ARIPiprazole 20 milligram oral once a day am for mood/psychosis
Prescribed By: Houde, Ashton NP (Nurse Practitioner), 8/18/2023

Biotin 5000 mcg capsule 5000 microgram oral once a day am (Patient buys OTC)

docusate 100 milligram oral once a day PRN constipation (Pt likes to take med every morning)
Prescribed By: Will, Christine A MD (Internal Medicine), 4/9/2024

Ferrous Sulfate 324 milligram oral once a day am
Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry), 8/18/2023

nadolol tablet 20 milligram oral once a day am
Prescribed By: Will, Christine A MD (Internal Medicine), 8/18/2023

OLANZapine 30 milligram oral once a day hs for psychosis (Take (2) 15 mg tablets (total dose=30 mg) PO QHS.)
Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry), 8/18/2023

omeprazole 40 milligram oral once a day am
Prescribed By: Will, Christine A MD (Internal Medicine), 8/18/2023

RisperDAL 2 milligram oral once a day am for mood/psychosis

G47.21	Circadian rhythm sleep disorder, delayed sleep phase type [ICD10]	11/15/2022 O	*Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry), 1/16/2024* RisperDAL 3 milligram oral once a day hs for mood/psychosis *Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry), 1/16/2024* rosuvastatin 5 milligram oral once a day hs for Cholesterol *Prescribed By: Velasco, German MD (Endocrinology), 8/18/2023* senna 17.2 milligram oral once a day am PRN Constipation *Prescribed By: Will, Christine A MD (Internal Medicine), 8/29/2023* Trulicity Pen 3 milligram subcutaneous once a week for lower a1c (Administer on WED AM) *Prescribed By: Cardoza, Gabriella NP (Nurse Practitioner), 5/28/2025* Vitamin D3 0.25 microgram oral once a day am *Prescribed By: Will, Christine A MD (Internal Medicine), 8/18/2023*
Z79.84	Long term (current) use of oral hypoglycemic drugs [ICD10]	7/6/2023 E	

14. DME and Supplies

Gloves-unsterile, Oxygen/Respiratory Equipment, CPAP machine, med box

15. Safety Measures

Evacuation plans, Medication confusion, Universal precautions

16. Nutritional Req.

No concentrated sweets

17. Allergies

propranolol, ciprofloxacin

18A. Functional Limitations

Anxiety, depression, poor insight and judgment, Altered thought process does not affect homebound status

18B. Activities Permitted

No restrictions

19. Mental Status

Oriented, Forgetful, Depressed, Anxiety

20. Prognosis

Fair

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

SN: 1x/da x 60 das (6/8/2025 to 8/6/2025)
PRNx3 S/SX Complications
_HEAD TO TOE:
Assess Head to Toe.
_PATIENT PERSONAL PLAN:
Patient identified steps toward personal goal: Patient will utilize coping skills.
_PATIENT RISK STATUS:
Patient Risk for Emergency Room use or Hospitalization is assessed to be: High and will be addressed with measures focusing on: medication compliance.
[HWC] MEDICATIONS:
C-Monitor the effectiveness of drug therapy, drug reactions, and side effects. Administer medications as per physician orders.
CARDIOVASCULAR STATUS:
Skilled Observation & Assessment of Heart Sounds.
DEPRESSION:
T-Teach importance of taking medications as prescribed. T-Teach prescribed medication use, actions and potential side effects. Assess for suicidal ideation. Provide patient/caregiver/family with written and/or oral education about signs and symptoms of depression. Make referrals to MD, MSW and/or community resources if appropriate.
EMERGENCY PREPAREDNESS:
In the event of an emergency or natural disaster, the patient prefers to evacuate to: hospital. The patient requires life saving equipment of: Med box. In the event of a power outage the patient has access to: N/A.
ENDOCRINE STATUS:
Skilled Observation & Assessment Blood Sugar per home glucose monitoring. Call Physician for BS below 50 or above 350. Skilled Observation & Assessment of Endocrine Status.
FOOT CARE:
T-Teach Patient/caregiver proper foot care. S/O presence of skin lesions on lower extremities.
GENERAL:
Skilled Observation & Assessment of Vital Signs. Report findings to MD if Systolic Blood Pressure > 180 or < 90. Report findings to MD if Diastolic Blood Pressure > 90 or < 50. Report findings to MD if Heart Rate > 120 or < 50. Report findings

to MD if Blood Glucose > 350 or < 50. Administer Trulicity weekly. Next Dose on WED AM. Medication(s) secured in lockbox for safety. Lockbox in working order..
HEART FAILURE:
Skilled Observation & Assessment of Cardiovascular Status.
MEDICATION MANAGEMENT:
Provide patient/caregiver/family with written and/or oral education on each medication including action, dose, side effects, interactions and adverse effects..
MEDICATIONS:
Skilled Observation & Assessment of Medication Use/Effect. T-Teach patient/caregiver how and when to report medication issues.
OASIS POC SYNOPSIS:
Provide patient/caregiver/family with written and/or oral education on how to perform regular skin exams, clean and dry feet, moisturize skin regularly, diabetic appropriate footwear.
PAIN - R & C:
C- Assess patient pain.
PSYCHOSOCIAL/ENVTAL:
Skilled Observation & Assessment of Psych/Social Needs.
SAFETY:
Equipment in Working Order

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Goal: Patient-stated personal goal: Patient would like to be able to relax. Medication Compliant. Monitor for sx of decompensation, increasing flat affect, AMS, paranoia, delusions, disorganized behavior, inappropriate laughing/smiling, responding to internal stimuli.
SN: Rehab Potential is Fair For the Above Goals
SN Discharge Plan: Discharge to Self Care

Clinical Summary SN: Makaela is a 30 year old woman who lives with her parents in a single family home in the community. She is alert and oriented x3. Pt is able to perform ADLs independently but needs assistance with IADLs such as medication management, shopping and finances. Patient is able to leave home to go out with family and friends, do errands and to go to medical appointments. She has a vehicle but chooses not to drive often due to fear. Due to patients paranoia caused by psychiatric illness, patient has no willing or able caregivers to assist her with medication management. She continues to have poor judgement and insight in disease process and medication management and is unable to manage on her own.

Interpreter services needed: None needed.

Recent Hospitalizations/ER visits: No recent hospitalizations or ER visits during the recert period.

Admission/Referral Source: Lucyna Dolliver, MD. PCP is Christine Will, MD.

Primary Diagnosis (specific condition):
(F25.0) Schizoaffective disorder, bipolar type

Rationale For Services
As a result of patient's complex history of mental and physical illnesses, patient has elevated health anxiety, paranoia, as well as poor insight and judgment and limited problem solving when it comes to independently managing her health. Patient is unable to correctly and safely administer her own medication as she gets overwhelmed and anxious, and requires skilled nursing for trulicity injection due to fear of injection. Without SNV, patient is likely to be noncompliant with her medications and she requires daily skilled nursing assistance with medication administration and education to maintain independence in community and prevent decompensation and hospitalization

Medication Reconciliation Completed with Physician.

Medication List provided to Patient and or Caregiver in writing.

Pain in the last 5-days interfering with activity/sleep. Patient denies pain upon recent assessment.

Depression Assessment. Patient denies increased depression at the time of assessment, reports "boredom" which can be a trigger/precursor to decompensation. Pt often presents with a blunted or dull affect. Pt frequently endorses symptoms of depression without identifying that she is feeling depressed, reporting that she is bored or irritable. Pt continues to have limited insight into her own feelings/triggers and can be guarded, increasingly so when she is feeling symptomatic. She denies SI/HI, AH/VH at this time. CFS.

Fall Risk Assessment: Patient is not at risk for falls as of current assessment.

Patient Rights and Responsibilities Reviewed with Patient, patient verbally agrees.

Plan of Care Reviewed with Patient, patient verbally agrees.

Summarize each pertinent diagnosis
Diabetes: Patient continues to make progress in managing her type 2 diabetes. Pt's diabetes is managed by Gabriella Cardoza, NP. Her fasting blood sugars have been stable during the recertification period and she denies any recent sx of hyper/hypoglycemia, including dizziness. Pt's Trulicity was recently increased to 3 mg SC weekly to help improve blood sugars, A1c and assist in weight loss. She denies any SE/ADE at this time. Her most recent A1c on 5/15 was 5.7. Pt's weight has remain unchanged and she admits to snacking on junk food at night. Education continues on diabetic diet and increasing physical activity.

COPD/resp failure: Pt has not complained of any respiratory concerns during the recert period. Lungs sounds are clear at baseline. She continues to utilize her CPAP nightly and demonstrates the ability to clean it daily. She denies SOB, chest pain, cough or wheezing. She has an albuterol inhaler that she can use PRN but patient has not required it. Pt continues to be educated on disease process and medications and how/when to use.

Schizoaffective Disorder/Anxiety: Pt's mood has been stable and no symptoms of decompensation reported or observed. No changes have been made to her daily medication regimen. Pt continues on abilify, risperdal and olanzapine for mood disorders/schizoaffective disorder. Patient has been compliant with appointments and medications as ordered by MD. She denies increased depression, anxiety, SI/HI and CFS. Pt continues to struggle with boredom and social isolation, education often focused on reviewing symptoms of decompensatuon with patient to help identify and intervene before patient decompensates.

Goal Progression: Patient has not required hospitalization or ER over the recertification period and has been making slow progress towards her goals. She is compliant with POC and skilled nursing visits. Pt continues to have anxiety and display rigidity in thinking when it comes to her medication and other health-related issues at baseline. She has been compliant with her appointments and follow up visits. She responds well to a daily routine and is compliant with checking her blood sugars, taking medications as ordered, keeping a calendar of appointments and reminders and following up with providers. Pt has been unable to administer her own Trulicity due to fear but remains compliant. Patient is actively working towards identifying and utilizing her coping skills to prevent psychiatric decompensation.

Vital Signs
SBP ranges: 92 - 134
DBP ranges: 55 - 84
HR ranges: 88 - 125
Temp ranges: WNL
BS ranges: 71 - 109 A1C: 5.7

Vaccination Status
Fully vaccinated for Covid with a Booster

Participants of Care
Dr. Christine Will (PCP)
Dr. Lucyna Dolliver (Psychiatrist)
Gabriella Cardoza, NP (Endrocrinology)
Dr. Martin (Pulmonology)
Innovive Health staff

Nurse's Signature and Date of Verbal SOC	Case Manager	Date HHA Received Signed POT
Diane Daley RN *E-Signature* 06/05/2025 @ 06:03 PM/Jessica Rock RN 6/4/2025 @ 10:40 AM	Jessica Rock RN	(Sent 6/6/2025)

Attending Physician's Signature and Date Signed

I certify that the patient had a F2F encounter on 08/03/2023 that was related to the primary reason for home health care and was conducted by an allowed practitioner. I certify/recertify that care is medically necessary and alternative is more costly. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan. I also acknowledge that I have received, reviewed and agree with the findings from the initial home health assessment which was attached to this plan of care. This assessment and plan of care have been added to the medical record for this patient. I certify that a face to face encounter was completed for the initial start of care

Signature**X** Electronically Signed by [ ] on [ ] Date**X**

Christine A Will, MD