

HOME HEALTH CERTIFICATION AND PLAN OF CARE

| | | | | |
|---|---|---|--|---|
| 1. Patient's HI Claim No. 115670 | 2. Start Of Care Date 11/5/2024 | 3. Certification Period From: 7/3/2025 To: 8/31/2025 | 4. Medical Record No. 1753 | 5. Provider No. 227550 |
| 6. Patient's Name and Address CONCEPCION GOMES (678) 668-6078 186 Rockway St Apt D New Bedford, MA 02740 | | | 7. Provider's Name, Address and Telephone Number All At Home Health Care (617) 782-9900 1842 Beacon St, Suite 404 F (617) 782-9800 Brookline , MA 02445 NPI: 1720386378 | |
| 8. Date of Birth 1/9/1941 | 9. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 10. Medications: Dose/Freq/Route (N)ew (E)xisting (C)hanged (D)iscont (E) amiodarone HCl(amiodarone HCl 200 mg ORAL tablet) tablet 100 mg 100 mg oral once a day Start Date: 11/5/2024 (E) apixaban(Eliquis 5 mg tablet) tablet 5 mg 5 mg oral 2 times a day Start Date: 11/5/2024 (E) ascorbic acid(ascorbic acid (vitamin C) 500 mg tablet) tablet 500 mg 500 mg oral once a day Start Date: 5/6/2025 (E) biotin(biotin 10 mg ORAL tablet) tablet 10 mg 10 mg oral once a day Start Date: 11/5/2024 (E) docusate sodium(docusate sodium 100 mg ORAL capsule) capsule 100 mg 100 mg oral 2 times a day Start Date: 11/5/2024 (E) flaxseed oil(flaxseed oil 1,000 mg ORAL capsule) capsule 1,000 mg 1,000 mg oral once a day Start Date: 11/5/2024 (E) L.acidoph,paracasei, B.lactis(Probiotic 10 billion cell capsule) capsule 10 billion cell 1 cap oral once a day Start Date: 11/5/2024 (C) tizanidine HCl(tizanidine HCl 2 mg ORAL tablet) tablet 2 mg daily as needed for spasm oral Start Date: 12/3/2024 End Date: 7/8/2025 (E) acetaminophen(Tylenol Arthritis Pain 650 mg tablet,extended release) tablet 650 mg 650 mg oral every 6 hours PRN as needed for pain Start Date: 11/5/2024 (E) bisacodyl(bisacodyl 5 mg ORAL tablet, delayed release (enteric coated)) tab 5 mg 5 mg oral once a day PRN as needed for constipation Start Date: 11/5/2024 (E) tizanidine HCl(tizanidine HCl 2 mg ORAL tablet) tablet 2 mg 2 mg oral once a day PRN as needed for spasm Start Date: 12/3/2024 | |
| 11. Diagnosis Code I48.0 | Principal Diagnosis Paroxysmal atrial fibril | Date 11/5/2024 | | |
| 12. Procedure Code | Surgical Procedure | Date | | |
| 13. Diagnosis Code G30.9 F02.818 F22 E78.5 D64.9 Z79.01 | Other Pertinent Diagnosis Alzheimer's disease, uns Dem in oth dis classd el Delusional disorders Hyperlipidemia, unspecif Anemia, unspecified Long term (current) use | Date 11/5/2024 11/5/2024 11/5/2024 11/5/2024 11/5/2024 11/5/2024 | | |
| 14. DME and Supplies Shower Chair, Walker, masks, gloves | | | 15. Safety Measures 911 Protocol, Emergency Plan Developed, Fall Precautions, Guard rails in bathroom, Home Safety Assessment, Infection Control Measures, Medication Safety/Storage, Signs and Symptoms to Report, Uncluttered Pathway, Universal Precautions, Use of Assistive Device | |
| 16. Nutritional Req Regular | | | 17. Allergies Bee Pollen, Iodinated Contrast Media, Miralax, Percocet | |
| 18.A Functional Limitations 1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind 2 <input type="checkbox"/> Bowel/Bladder 6 <input type="checkbox"/> Endurance A <input type="checkbox"/> Dyspnea w/ME 3 <input type="checkbox"/> Contracture 7 <input checked="" type="checkbox"/> Ambulation B <input type="checkbox"/> Other (Specify) 4 <input type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech | | | 18.B Activities Permitted 1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Wt. Bear A <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Indep at Home B <input checked="" type="checkbox"/> Walker 3 <input type="checkbox"/> Up as Tolerated 8 <input type="checkbox"/> Crutches C <input type="checkbox"/> No Restrictions 4 <input type="checkbox"/> Transfer Bed/Chair 9 <input type="checkbox"/> Cane D <input type="checkbox"/> Other (Specify) 5 <input type="checkbox"/> Exercises Prescribed | |
| 19. Mental Status | 1 <input checked="" type="checkbox"/> Oriented 2 <input type="checkbox"/> Comatose | 3 <input checked="" type="checkbox"/> Forgetful 4 <input type="checkbox"/> Depressed | 5 <input type="checkbox"/> Disoriented 6 <input checked="" type="checkbox"/> Lethargic | 7 <input type="checkbox"/> Agitated 8 <input type="checkbox"/> Other |
| 20. Prognosis | 1 <input type="checkbox"/> Poor 2 <input checked="" 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 1WK8 - effective 7/6/2025 - Recertification summary: Patient is a 83-year-old female with PMH significant for atrial fibrillation, dementia, Alzheimer's, hyperlipidemia, and anemia. Patient lives alone in a one bedroom apartment within a housing complex and is non homebound. Patient has a daughter and sister who live nearby who are supportive and available to assist patient in an emergency. Patient was referred to agency for medication management and has been compliant with weekly SNV for med minder fill, assessment, and education. Patient is unable to manage her medications independently due to her cognitive decline and inability to identify medications or state their doses, indications, administration times, side effects, etc. Patient denies any pain at this time. Patient ambulates with walker due to unstable gait. SN to continue with ongoing in home safety assessments as well as education on safety precautions in and outside of the home to prevent falls and injuries. Patient continues on Eliquis twice daily for clot prevention associated with A-Fib. SN monitors closely for s/s bleeding and educates patient on these s/s frequently. SN to continue with 1x/weekly visits to ensure proper medication mgmt. Recertification visit vital signs: temp 97.8 F, HR 68, RR 18, O2 sat 97 % on RA at rest, BP 136/80. | | | | |

Patient cleaning her outside porch at time of sn arrival. Patient disheveled in appearance with anxious affect yet

HOME HEALTH CERTIFICATION AND PLAN OF CARE

| | | | | |
|--|------------------------------------|--|-------------------------------|---------------------------|
| 1. Patient's HI Claim No. 115670 | 2. Start Of Care Date 11/5/2024 | 3. Certification Period From: 7/3/2025 To: 8/31/2025 | 4. Medical Record No. 1753 | 5. Provider No. 227550 |
| 6. Patient's Name and Address CONCEPCION GOMES 186 Rockway St Apt D New Bedford, MA 02740 | | 7. Provider's Name, Address and Telephone Number All At Home Health Care 1842 Beacon St, Suite 404 Brookline , MA 02445 | | |
| (678) 668-6078 | | (617) 782-9900 F (617) 782-9800 NPI: 1720386378 | | |

pleasant and cooperative with care throughout visit. CP assessment wnl. Patient denies any sob/chest pain. Patient denies any si/hi or ah/vh at this time. Patient denies any s/s resp distress or s/s covid19. Patient noncompliant with prepped doses x 3 since last snv. Patient shrugs shoulders when asked about missed doses. SN prepoured remaining doses up until next snv. SN will assess for compliance at that time. Patient denies any negative side effects to medications. abdomen soft and nontender. + BS x 4 quads. BM WNL. Patient denies any gi/gu concerns at this time. SN educated patient on the importance of med compliance and risks of missed doses. Patient smiles. SN will cont to educate and monitor. Plan of care reviewed with the patient who verbalized understanding and agreed.

22.Goals/Rehabilitation Potential/Discharge Plans

Patient will comply with SNV, plan of care, medication regimen, and MD appointments.

Patient will verbalize and demonstrate understanding of symptom management, resource utilization and medication management to reduce unplanned hospital or emergency department visits.

Patient will develop positive coping skills to manage feelings of anxiety/depression.

Patient will remain safely at home and in the community with clinical management by SN and MD follow-up until independent with care. Patient will be discharged when goals are met and patient is safe and independent at home or when patient is no longer in need of skilled nursing services. Discharge plans discussed with patient. Rehab potential is poor.

| | |
|--|---|
| Disaster information 3:Low Priority-Stable, can miss visit: Individual emergency plan details - get outside | POC collaboration Attending/Certifying Physician notified and VO for POC received: Yes Collaborated with additional Physicians involved in patient's care : No Care Coordination and Plan of Care Collaboration with: SN, Patient/Family/CG Names of physicians that collaborated in POC: Dr. |
| Strengths, goals, care preferences Patient Strengths: Patient willing to participate in POC. Patient Preferences to include requested schedules: No preferences. Patient/Family Goals: Patient will remain safe at home within the community and free from hospitalization. | Patient representative Patient does not have representative. |
| Patient risk for Hospital and ER Risk Information: Currently taking 5 or more medications. Other risks not listed. | Willingness and ability of CG Primary Caregiver: Not willing to provide care Primary Caregiver Schedules for Care: No willing or able caregiver available. |

Advanced Directives

Full code

Advanced Directives narrative

*Full code

Vital Sign Parameters - (Contact physician if the following is outside of parameters)

Temperature: low value 96.0 to high value 101.0

Pulse: low value 50.0 to high value 100.0

Respiratory Rate: low value 12.0 to high value 24.0

Systolic Blood Pressure: low value 90.0 to high value 160.0

Diastolic Blood Pressure: low value 60.0 to high value 90.0

O2 Saturation: low value 90.0 to high value 100.0

Pain: low value 0.0 to high value 8.0

Reasons for Homebound & Medical Necessity

HOMEBOUND: NO - NOT HOMEBOUND. Patient is able to leave home to do errands, shopping, visit family and friends.

CARE NEEDS

21CN. Comment:

The PHI (personal health information) contained in this document is highly confidential. It is intended for the exclusive use of the addressee. It is to be used solely in conjunction with providing specific healthcare services to this patient. Any other use is a violation of federal law (HIPAA) and will be reported as such.

C-10839

| HOME HEALTH CERTIFICATION AND PLAN OF CARE | | | | |
|--|------------------------------------|--|-------------------------------|---------------------------|
| 1. Patient's HI Claim No. 115670 | 2. Start Of Care Date 11/5/2024 | 3. Certification Period From: 7/3/2025 To: 8/31/2025 | 4. Medical Record No. 1753 | 5. Provider No. 227550 |
| 6. Patient's Name and Address CONCEPCION GOMES 186 Rockway St Apt D New Bedford, MA 02740 | | 7. Provider's Name, Address and Telephone Number All At Home Health Care 1842 Beacon St, Suite 404 Brookline , MA 02445 | | |
| | | (678) 668-6078 (617) 782-9900 F (617) 782-9800 NPI: 1720386378 | | |

22CN. Patient/Family Goals

| Care Need | Discipline | Care Need Level |
|---|-----------------|--|
| ASSESSMENT OF CARDIOVASCULAR SYSTEM | RN (07/03/2025) | |
| Goal Patient will verbalize Side effect of Eliquis, and compliant with Bleeding precautions, In Process | | Intervention Instruct on indication, side effects and bleeding precautions - medication Eliquis |
| ASSESSMENT OF MEDICATION MANAGEMENT | RN (07/03/2025) | |
| Goal Patient/Caregiver adheres to/demonstrates compliance with multiple medication regimens by the end of cert period, In Process | | Intervention Instruct patient on med-planner, via med minder ,assist in prefill and assess for compliance with medications |
| ASSESSMENT OF NEUROLOGICAL SYSTEM | RN (07/03/2025) | |
| Goal Pt/cg will verbalize measure to manage neurological condition by the end of the certification period. , In Process | | Intervention Instruct on Dementia/Alzheimer's disease |
| DISCHARGE PLANNING | RN (07/03/2025) | |
| Goal Patient will be discharged when medical condition stable and patient no longer in need of skilled care, In Process | | Intervention Evaluate knowledge of, and agreement with, discharge plan |

The PHI (personal health information) contained in this document is highly confidential. It is intended for the exclusive use of the addressee. It is to be used solely in conjunction with providing specific healthcare services to this patient. Any other use is a violation of federal law (HIPAA) and will be reported as such.

C-10839

HOME HEALTH CERTIFICATION AND PLAN OF CARE

| | | | | |
|--|------------------------------------|--|-------------------------------|---------------------------|
| 1. Patient's HI Claim No. 115670 | 2. Start Of Care Date 11/5/2024 | 3. Certification Period From: 7/3/2025 To: 8/31/2025 | 4. Medical Record No. 1753 | 5. Provider No. 227550 |
| 6. Patient's Name and Address CONCEPCION GOMES 186 Rockway St Apt D New Bedford, MA 02740 | | 7. Provider's Name, Address and Telephone Number All At Home Health Care 1842 Beacon St, Suite 404 Brookline , MA 02445 | | |
| | | (678) 668-6078 (617) 782-9900 F (617) 782-9800 NPI: 1720386378 | | |

| | | |
|---|--|---|
| 23. Nurse's Signature and Date of Verbal SOC Where Applicable Xavier, Lindsay (RN) Electronically signed by: Lindsay Xavier, RN | 7/1/2025 2:15 PM 7/5/2025 | 25. Date of HHA Received Signed POT |
| 24. Physician or other approved provider name and address Sachin Maskey, 531 Faunce Corner Road North Dartmouth, MA 02747 | W: 508-996-3991 F: 508-961-0949 NPI: 1134386972 | 26. 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 services on this plan of care and will periodically review the plan. |
| 27. Physician or other approved provider Signature and Date Signed | 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. | |

Clinician Attestation

I certify that this medical record entry for Physician's orders accurately reflects the most recent assessment of the patient's condition as well as a verbal conversation with the physician to provide these services. I understand that signing this document electronically is the legal equivalent of having placed my handwritten signature on this document. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission or concealment of material fact may be subject me to administrative, civil or criminal liability.

Electronically signed and dated by:

| | | | | | | |
|-------------------|--------------------|-----------|---------|----------|---------|-----------------------|
| Lindsay Xavier RN | Lindsay Xavier, RN | | 1094 | 7/5/2025 | 5:38 PM | Central Standard Time |
| Signature | Associate Name | License # | User ID | Date | Time | Time Zone |

Approval Attestation

I certify that this medical record entry for Physician's orders accurately reflects the most recent assessment of the patient's condition as well as a verbal conversation with the physician to provide these services. I understand that signing this document electronically is the legal equivalent of having placed my handwritten signature on this document. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission or concealment of material fact may be subject me to administrative, civil or criminal liability.

Electronically signed and dated by:

| | | | | | | |
|-----------------|----------------|-----------|---------|----------|----------|-----------------------|
| Dagmar Kotov RN | Dagmar Kotov | | 1053 | 7/9/2025 | 12:37 PM | Central Standard Time |
| Signature | Associate Name | License # | User ID | Date | Time | Time Zone |

The PHI (personal health information) contained in this document is highly confidential. It is intended for the exclusive use of the addressee. It is to be used solely in conjunction with providing specific healthcare services to this patient. Any other use is a violation of federal law (HIPAA) and will be reported as such.

C-10839