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.
2A71X89JF39	06/16/2025	06/16/2025 Through 08/14/2025	6675015	227027

Physician Name and Address

Shan Qin, MD
Hawthorn Medical Associates
531 Faunce Corner Rd
Dartmouth, MA 02747
(508) 996-3991 Fax (508) 961-0876

Patient

Sullivan, Dennis B
30 Sarah Beth Lane
Rochester, MA 02770

DOB

06/26/1937

Sex

M

Directives In Place/Risk of Hospitalization

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)
- Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- Currently taking 5 or more medications
- Currently reports exhaustion
- Other Risk

Provider Name and Address

Community Nurse Inc
62 Center Street
Fairhaven, MA 02719
(508) 992-6278
Fax (508) 997-3091

11. Dx Code	Principal Diagnosis	Date
G20.A1	Parkinson's disease without dyskinesia, without mention of fluctuations [ICD10]	6/12/2025 E

12. Dx Code	Surgical Procedure	Date
N/A		

13. Dx Code	Other Pertinent Diagnoses	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny [ICD10]	6/12/2025 E
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease [ICD10]	6/12/2025 E
N18.32	Chronic kidney disease, stage 3b [ICD10]	6/12/2025 E
D63.1	Anemia in chronic kidney disease [ICD10]	6/12/2025 E
G47.30	Sleep apnea, unspecified [ICD10]	6/12/2025 E
G89.29	Other chronic pain [ICD10]	6/12/2025 E
M54.50	Low back pain, unspecified [ICD10]	6/12/2025 E
R63.4	Abnormal weight loss [ICD10]	6/12/2025 E
L89.312	Pressure ulcer of right buttock, stage 2 [ICD10]	6/12/2025 E
E78.5	Hyperlipidemia, unspecified [ICD10]	6/12/2025 E
E53.9	Vitamin B deficiency, unspecified [ICD10]	6/12/2025 E
Z87.442	Personal history of urinary calculi [ICD10]	6/12/2025 E
Z87.891	Personal history of nicotine dependence [ICD10]	6/12/2025 E
Z87.81	Personal history of (healed) traumatic fracture [ICD10]	6/12/2025 E
Z85.46	Personal history of malignant neoplasm of prostate [ICD10]	6/12/2025 E
Z91.81	History of falling [ICD10]	6/12/2025 E
Z79.82	Long term (current) use of aspirin [ICD10]	6/12/2025 E
Z79.84	Long term (current) use of oral hypoglycemic drugs [ICD10]	6/12/2025 E

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

Adult Low Dose Aspirin 81 mg tablet, delayed release 1 tablets oral once a day (N)
Alpha Lipoic 300 mg tablet 1 tablets oral once a day (N)
atorvastatin 10 mg tablet 1 tablets oral every other day (N)
carbidopa 10 mg-levodopa 100 mg tablet 1 tablets oral 3 times a day (N)
cyanocobalamin (vit B-12) 1,000 mcg tablet 2.5 tablets oral once a day (2500mg Daly) (N)
Dulcolax (bisacodyl) 5 mg tablet,delayed release 1 tablets oral 2 times a day (N)
escitalopram 5 milligram oral once a day (N)
lisinopriL 40 mg tablet 1 tablets oral once a day (N)
metFORMIN ER 750 mg tablet, extended release 24 hr 2 tablets oral once a day (N)
repaglinide 2 mg tablet 1 tablets oral once a day (Dinner) (N)
Tart Cherry Extract 1,000 mg capsule 1 cap(s) oral once a day (N)
Vitamin D3 25 mcg (1,000 unit) tablet 1 cap(s) oral once a day (125mcg daily) (N)
Zonegran 100 mg capsule 1 cap(s) oral 2 times a day (N)

14. DME and Supplies

15. Safety Measures

Electronically Signed by [ ] on [ ]

Rolling walker, grab bars, raised toilet seat with handles, shower seat, handheld shower.	Avoid temperature extreme, Bleeding precautions, Blood and body fluid prec., Evacuation plans, Fall precautions, Fire, electric, & open flame safety, Hand railings, Lifeline, Night light, No ambulation w/o assist, No straining, Ramps, Universal precautions, Use of safety devices in bathroom
16. Nutritional Req.	**17. Allergies**
No concentrated sweets, Cardiac	NKA
18A. Functional Limitations	**18B. Activities Permitted**
Ambulation, Bowel/Bladder (Incontinence), Dyspnea w/minimal exertion, Endurance, Hearing, Pain	Up as tolerated, Walker
19. Mental Status	**20. Prognosis**
Oriented, Forgetful, intermittent confusion	Fair

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

SN: 2x/wk x 1 wk, 1x/wk x 8 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: Cardiopulm assess &vital signs, neuro assess & energy conserve teach, safety assess & fall prevent teach, med manage & teach, nutrition/hydration, pain assess & manage teach, endocrine assess & teach, integument assess & skin breakdown prevent teach. Skilled Observation & Assessment of Cardiovascular Status, Endocrine Status, GI Status, GU Status, Medication Use/Effect, Neuromuscular Status, Nutrition/Hydration, Respiratory Status, S/SX Infection, S/SX Pressure/Breakdown, 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. S/O for signs/symptoms of Depression. S/O presence of skin lesions on lower extremities. T-Teach importance of taking medications as prescribed. T-Teach Interventions to reduce pressure on areas at risk for skin breakdown. 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, Neuromuscular Disease Process, S/SX of Wound Infection, Skin & Foot Care, Use of Softners, Wound Care Procedure to PT/SO. Wound # 1 - Pressure Injury - posterior_right_buttock - Wound # 1 stage 2 pressure ulcer to right buttock, cleanse with mild soap and water followed by barrier cream 2x daily and as needed. SN to assess on visit days. Refer to ST for eval
PT: Start on 06/17/2025: 1x/wk x 1 wk, 1-2x/wk x 2 wks, 1x/wk x 6 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. Bed Mobility Training. C- Assess patient pain. Fall Prevention Instruction. Gait Training With FWB Using Rolling Walker. Patient/Caregiver Education. Provide With Activities to Enhance Balance. Recommend Equipment As Needed. Recommend Equipment As Needed. Safety Precaution Instruction. T-Teach frequent position changes. T-Teach Interventions to prevent pressure ulcers. Teach ROM Exercises. Teach- Interventions to monitor and mitigate pain. Therapeutic exercises focused on improving trunk/LE flexibility and strength, balance, endurance/activity tolerance and safety during functional mobility.. Transfer Training. Teach Activities to Enhance Endurance, Body Mechanics, Breathing Technique/Exercise, Home Exercise Program, Home Safety, Pacing & Energy Conservation Techniques. Positioning ed
OT: Once every 14 das x 14 das
OT eval pending
HCA: Start on 06/22/2025: 2x/wk x 2 wks
Assist With Personal Care
Diet: Once every 14 das x 14 das
Diet eval pending

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Patient Stated Personal Goal: Long Term Goal: Be able to step out of shower easier within cert period. Implements Safety Measures To Decrease Risk Of Injury within cert period. Patient Stated Personal Goal- Short Term Goal: move more, easier within cert period. Pressure ulcers will heal with no s/sx of infection or complications 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: Long Term Goal: Follow Home Exercise With Assist of Family/Caregiver. Long Term Goal: Patient-stated personal goal: "more strength, and better balance". Long Term Goal: Prevent Contractures. Long Term Goal: Prevent Skin Breakdown. Long Term Goal: The patient will experience less interfering pain as evidenced by improved mobility. Long term goal: Good safety/energy conservation awareness during all functional mobility, to reduce risk for falls. Short term goal: Pt will be active with a daily HEP and ambulation program. Long term goal: Increase trunk/LE flexibility and strength >/= 1 grade, for improved ease/safety during bed mobility and transfers/ambulation, and reduced risk for falls. Long term goal: Safe bed mobility, with min assist if needed. Long term goal: Safe transfers and ambulation with a RW and supervision, to access all rooms in the home for ADLs. Long Term Goal: The patient will demonstrate improved functional lower extremity strength by improving 30 second sit to stand score to >/= 5, for improved safety/reduced risk for falls during functional mobility. Long Term Goal: Patient will demonstrate improved balance as evidenced by Tinetti score of >/= 14 in order to reduce risk for falls, and with no reports of falls within 8 weeks
OT Goals: OT Eval pending
HCA Goals: Pt's ADL Status Will Be Maintained within cert period
Diet Goals: Diet eval pending

SN: Rehab Potential is Good For the Above Goals
PT: Rehab Potential is Fair For the Above Goals

HCA: Rehab Potential is Good For the Above Goals
Discharge Plan: Discharge to Care of Family With Supportive Services
Clinical Summary SN: SOC: 87-year-old married male referred by primary care physician for home care services, including Nursing, PT, and OT, with a primary diagnosis of Parkinson's disease.

Primary DX: Parkinson's disease without dyskinesia

PMH: Parkinson's disease, type 2 diabetes, nephrolithiasis status post laser lithotripsy, prostate cancer, hyperlipidemia, anemia, retinal detachment, chronic kidney disease stage 3, low back pain

COGNITION: Alert and oriented times 3, somewhat hoarse voice with low volume, admits to slowed word finding at times. Patients wife states, "Speech is hoarseness and sometimes he's slow with word finding, sometimes he's confused."

NEURO: muscular rigidity, fine tremor to left hand and arm. Patient denies any blurred vision or dizziness. Patient's wife reports patient wtih Intermittent confusion not all the time. Patient states, "I have been having terrible very vivid violent dreams. Sometimes in the day I get the feeling that my house been removed from ROchester to another town, or that the orientation is different." Patient has telemedicine visits with neurologist Dr. Arun Rajan tomorrow, encouraged patient to discuss this with neurology, also to review if carbidopa/levodopa can be adjusted if this has not in some time, reviewed that zonisamide can also be adjusted if neurology feels this is causing dreams. Encouraged patient to discuss this with neurology.

CARDIOVASCULAR: Heart rate regular, blood pressure is orthostatic going from 128/70 down to 100/60 from sitting to standing. Denies dizziness and lightheadedness. Trace ankle edema.

PULMONARY: lung sounds clear diminished at bases no rhales, no rhonchi. Observed shortness of breath with minimal exertion from sit to stand and with ambulating. No cough; uses CPAP at night.

BORG: 0

MOBILITY/ADL's: patient requiring assist from sit to stand using electric lift recliner. Patient's wife states, ""His steps were short before but now his steps are shuffle" observed patient with shuffling festinant gait with rolling walker, observed rolling walker brakes do not work. Patient wished to remain barefoot, requested patient wear rubber soled shoes or slippers for safety. Patient and wife report decline in ability to initiate and complete ADLs over the past 6-8 weeks due to increased weakness, fatigue and rigidity. Patients wife states, "I was getting him in to the shower, I''m having a very difficulty time getting him out of the shower, stepping over the at lip."

SKIN: Right buttock with stage 2 pressure ulcer 0.4 by 0.4 cm, appearing denuded. Caregiver wife is using barrier cream several times a day. Skin to hips, front skin folds, spine, heels, feet, and groin intact.

PAIN: Reports lower back pain at baseline, does not take anything for this.

GI/GU: Reports no issues with urinary stream, denies burning or pain with urination. Denies issues moving bowels and diarrhea. Takes Dulcolax as needed for constipation.

ENDOCRINE: Type 2 diabetic, currently taking oral hypoglycemics, does not check blood sugars. Last recorded hemoglobin A1C was 6.9%.

DIET/NUTRITION: Reports decreased appetite, agreeable to dietitian for protein sources and continued muscle maintenance.

WEIGHT/MEASUREMENTS: Unable to be weighed due to unsteady gait and balance. Reports a loss of approximately 10 to 15 pounds over the last year.

SAFETY: High risk of fall with several falls reported by patient and wife over the last three months with no injury. Has a Life Alert.

MEDS: Medications in home matching PCP referral list with some discrepancies noted in dosing of vitamin D.

DEPRESSION: history of anxiety, denies depression

LIVING SITUATION: Lives in a single-family 55 and older community with his wife.

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

GOALS: (Short Term and Long Term): move more, easier; be able to step put of shower easier.

HEALTH LITERACY: mod

EMERGENCY PREPAREDNESS PLAN: Shelter in place.

CODE STATUS/ADVANCED DIRECTIVES: Full code.

COMMUNITY RESOURCES: Coastline Elder Services for Life Alert.

UPCOMING APPOINTMENTS: Neurology telemedicine visit tomorrow.

REFERRALS:
SN:
PT:
OT:
ST:
DIET:
TELEMED:

SKILL/REASON FOR HOME CARE: Cardiopulm assess &vital signs, neuro assess & energy conserve teach, safety assess & fall prevent teach, med manage & teach, nutrition/hydration, pain assess & manage teach, endocrine assess & teach, integument assess & skin breakdown prevent 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 Dennis B Sullivan who verbalizes understanding and agrees to participate.

PPE: universal precautions
PT: PT SOC summary: Pt is a very pleasant 87-year-old male. He was seen for admission to Community Nurse on 6/16/25 by SN: "referred by primary care physician for home care services, including Nursing, PT, and OT, with a primary diagnosis of Parkinson's disease. Primary DX: Parkinson's disease without dyskinesia". Referred for home PT to address safety, gait mobility, and strengthening.

PMH: Parkinson's disease, type 2 diabetes, nephrolithiasis status post laser lithotripsy, prostate cancer, hyperlipidemia, anemia, retinal detachment, chronic kidney disease stage 3, low back pain

Soc HX: Patient lives with his wife in a 2 story townhouse. His wife is present, and his daughter arrived during the visit. Pt/wife report PLOF includes: ambulating with a rollator walker for the past 3 months and using a cane prior, assist with dressing and showering, ambulating independently with the st cane in the home and using the stairs/walking short distances outdoors with the st cane and supervision-approx 3 months ago. Equipment: PERS, rollator walker, gait belt, power lift recliner, shower stall-low built in seat/suction cup grab bar, commode over the toilet, transport W/C in the garage. They are considering getting a hospital bed or adjustable bed, and a stair lift installed on the stairs to/from the garage.

CODE STATUS: Full code

COGNITION: A&Ox3, wife reports he is forgetful and confused at times; very pleasant and cooperative.

CURRENT LEVEL OF FUNCTION: Pt presents with chronic low back pain, decreased trunk/LE flexibility and strength, decreased independence with bed mobility, difficulty with transfers-requiring assist, impaired balance, an unsteady/shuffled gait-presently using a rollator walker and requiring assist, risk for falls, and decreased safety/independence during functional mobility. Bed mobility: Pt/wife report he has been sleeping in the recliner for the last 2 weeks, due to difficulty getting in/out of bed during the night when he needs to use the bathroom; rolling and supine to sit-mod assist, with VCs, sit to supine-min assist, with VCs. Transfers sit/stand with the rollator walker (power lift recliner, bed, toilet with commode)-min assist, with VCs for safe/proper technique-locking the brakes, hand placement, positioning/body mechanics. Ambulated approximately 30 ft x 4 with the rollator walker: forward flexed posture, narrow BOS, decreased step height/length/HS, shuffled, unsteady-min assist, with VCs for improved balance, gait pattern, and safety. Recommended using a 2 wheeled RW instead of the rollator, for improved stability and safety-pt/wife in agreement with plan to try one during the next visit.

SAFETY: High risk for falls; The home has 5 stairs with a rail-to exit/enter in front, 4 stairs with a rail-to exit/enter thru the garage; Bedroom and full bathroom are on the 1st floor.

SKILL/REASON FOR THERAPY SERVICES: Patient's goal: "more strength and better balance". Continued skilled home PT is indicated for safety/fall prevention ed, energy conservation ed, pain management, gentle ROM/stretching and ther exercise, balance training, functional mobility training (bed mobility, transfer/gait training with the rollator and a st RW, A.D. recommendations/ordering as appropriate) positioning/body mechanic ed, HEP instruction, caregiver ed prn, and cardiovascular monitoring. Without continued home PT intervention, patient is at risk for falls or further debility with increased dependence on caregivers and decreased quality of life. SN to continue at this time, OT to evaluate.

Homebound: Parkinson's disease, decreased flexibility/strength, impaired balance/unsteady gait, high risk for fall, requires assist of a person and device-including a transport W/C for distances, has stairs to exit/enter, taxing effort to leave the home.

ESTIMATED # VISITS: 11

24/7 CNHC availability and red flags reviewed

POC REVIEW: Plan of care reviewed with pt and his wife, who verbalized understanding and agree to participate. MD was informed of patient's POC.

Consent form reviewed with pt and his wife, both verbalized understanding. This writer witnessed pt signing the consent and form scanned to office. J. Seguer PT

Nurse's Signature and Date of Verbal SOC	Case Manager	Date HHA Received Signed POT
Kathy Lee Rodrigues RN *E-Signature* 07/07/2025 @ 02:56 PM/Tara Danley RN 6/16/2025 @ 05:00 PM	Janie Seguer PT-MA Lic# 8621	(Sent 7/8/2025)

Attending Physician's Signature and Date Signed

I certify that the patient had a F2F encounter on 06/11/2025 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**

Shan Qin, MD

Electronically Signed by [ ] on [ ]