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.
100220368755	10/19/2022	06/05/2025 Through 08/03/2025	1664020	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

Rivers, Shaun
156 Marion Rd
Rochester, MA 02770

DOB

07/25/1962

Sex

M

Directives In Place/Risk of Hospitalization

Advance Care Plan Discussion - Discussion held, patient unable 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
E11.9	Type 2 diabetes mellitus without complications [ICD10]	7/15/2022 E

12. Dx Code	Surgical Procedure	Date
N/A		

13. Dx Code	Other Pertinent Diagnoses	Date
F20.0	Paranoid schizophrenia [ICD10]	7/15/2022 E
F31.9	Bipolar disorder, unspecified [ICD10]	8/16/2022 E
K86.1	Other chronic pancreatitis [ICD10]	12/21/2024 O
K80.80	Other cholelithiasis without obstruction [ICD10]	12/21/2024 O
J44.9	Chronic obstructive pulmonary disease, unspecified [ICD10]	7/15/2022 E
Z79.4	Long term (current) use of insulin [ICD10]	7/15/2022 E
I50.32	Chronic diastolic (congestive) heart failure [ICD10]	1/1/2022 O
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris [ICD10]	7/15/2022 E
I10	Essential (primary) hypertension [ICD10]	7/15/2022 E
J85.0	Gangrene and necrosis of lung [ICD10]	9/23/2022 O
E78.5	Hyperlipidemia, unspecified [ICD10]	7/15/2022 E
G47.00	Insomnia, unspecified [ICD10]	7/15/2022 E
E55.9	Vitamin D deficiency, unspecified [ICD10]	7/15/2022 E

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

acetaminophen 650 milligram oral every 6 hours PRN pain or temp 100 or above
Prescribed By: Houlihan, Shannon NP (Family Practice), 12/13/2023
ARIPiprazole 10 milligram oral once a day
aspirin 81 milligram oral once a day
atorvastatin 20 milligram oral once a day
Breo Ellipta 1 puffs inhalation once a day
dapagliflozin 5 milligram oral once a day for diabetes
Diabetic Tussin DM 10 milliliter oral every 4 hours PRN cough
docusate 100 milligram oral once a day
Flomax 0.8 milligram oral once a day
HumaLOG 0 - 24 unit subcutaneous 3 times a day am pm noon ac for DM2 (***AM, NOON, PM ONLY *** If BS <150 no insulin, If BS 151-200 give 6 units, If BS 201-250 give 10 units, If BS 251-300 give 14 units, If BS 301-350 give 16 units, If BS 351-400 give 20 units, If BS > 400 give 24 units and notify provider)
Prescribed By: Matrisciano, Justin MD (Endocrinology), 1/29/2024
isosorbide mononitrate 30 milligram oral once a day
Lantus 100 units/mL solution 15 unit subcutaneous once a day pm for dm2
Prescribed By: Matrisciano, Justin MD (Endocrinology), 11/21/2024
Lantus Solostar Pen 22 unit subcutaneous once a day am for diabetes
Prescribed By: Matrisciano, Justin MD (Endocrinology), 1/7/2025
lisinopril 5 milligram oral once a day am
Prescribed By: Pajak, Slawomir MD (Internal Medicine), 6/28/2023
magnesium hydroxide 30 milliliter oral once a day PRN

G47.33	Obstructive sleep apnea (adult) (pediatric) [ICD10]	7/15/2022 E
K21.9	Gastro-esophageal reflux disease without esophagitis [ICD10]	7/15/2022 E
N40.0	Benign prostatic hyperplasia without lower urinary tract symptoms [ICD10]	7/15/2022 E
M25.552	Pain in left hip [ICD10]	7/15/2022 E
R32	Unspecified urinary incontinence [ICD10]	7/15/2022 E
E66.01	Morbid (severe) obesity due to excess calories [ICD10]	8/16/2022 E
Z68.38	Body mass index (BMI) 38.0-38.9, adult [ICD10]	7/15/2022 E
Z87.891	Personal history of nicotine dependence [ICD10]	7/15/2022 E
G31.84	Mild cognitive impairment, so stated [ICD10]	8/16/2022 E
F10.10	Alcohol abuse, uncomplicated [ICD10]	7/15/2022 E
Z79.84	Long term (current) use of oral hypoglycemic drugs [ICD10]	7/15/2022 E
F41.9	Anxiety disorder, unspecified [ICD10]	9/28/2022 E
Z87.820	Personal history of traumatic brain injury [ICD10]	9/28/2022 E
I45.19	Other right bundle-branch block [ICD10]	9/28/2022 E
S22.42XD	Multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing [ICD10]	12/21/2024 O

constipation
metFORMIN 1000 milligram oral 2 times a day
Metoprolol Tartrate 50 milligram oral 2 times a day
omeprazole 20 milligram oral once a day am
polyethylene glycol 3350 34 gram oral once a day hs
Prescribed By: Pappas, Alexis MD, 12/13/2023
roflumilast 500 microgram oral once a day
Prescribed By: Houlihan, Shannon NP (Family Practice), 10/18/2023
Rozerem 8 milligram oral once a day
Prescribed By: Houlihan, Shannon NP (Family Practice), 2/15/2023
SEROquel 50 milligram oral once a day hs
thiamine 100 milligram oral once a day
tiotropium 18 microgram inhalation once a day
torsemide 20 milligram oral once a day
traZODone 75 milligram oral once a day
trospium 20 milligram oral 2 times a day
Ventolin HFA 2 puffs inhalation every 4 hours PRN shortness of breath
Vitamin D3 50 microgram oral once a day

14. DME and Supplies

Gloves-unsterile, Oxygen/Respiratory Equipment, diabetic supplies, medbox

15. Safety Measures

Evacuation plans, Fall precautions, Fire, electric, & open flame safety, Hand railings, Needle disposal precautions, Oxygen precautions, Ramps, Universal precautions

16. Nutritional Req.

No concentrated sweets

17. Allergies

NKA

18A. Functional Limitations

Bowel/Bladder (Incontinence), Dyspnea w/minimal exertion, altered thought process that does not affect homebound status

18B. Activities Permitted

No restrictions

19. Mental Status

Oriented, Forgetful, Depressed

20. Prognosis

Fair

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

SN: 1x/da x 60 das (6/5/2025 to 8/3/2025)
PRNx3 Complications/Med Changes
_HEAD TO TOE:
Assess Head to Toe.
_PATIENT PERSONAL PLAN:
Patient identified steps toward personal goal: Medication compliance, reduce binge eating, attend medical appointments.
_PATIENT RISK STATUS:
Patient Risk for Emergency Room use or Hospitalization is assessed to be: High and will be addressed with measures focusing on: Assess assess blood sugar, assess respiratory status..
[HWC] MEDICATIONS:
C-Monitor the effectiveness of drug therapy, drug reactions, and side effects.

EMERGENCY PREPAREDNESS:
In the event of an emergency or natural disaster, the patient prefers to evacuate to: Alternative group home. The patient requires life saving equipment of: Insulin lockbox. In the event of a power outage the patient has access to: Standby generator and oxygen.
ENDOCRINE STATUS:
Skilled Observation & Assessment of Hypo/Hyperglycemic Reactions. Administer Insulin As Ordered. Teach S/SX Prevention, Treatment of Hypo/Hyperglycemia. Teach Diabetic Foot Care including: checking feet for cuts, redness, swelling, sores, blister, corns, calluses, or changes to skin or nails; washing feet in warm water then drying completely. Educate the client on wearing footwear and to avoid walking barefoot..
FALL PREVENTION:
Provide patient/caregiver/family with written and/or oral education about fall prevention..
GENERAL:
Skilled Observation & Assessment of Vital Signs. Report findings to MD if Systolic Blood Pressure > 160 or < 110. Report findings to MD if Diastolic Blood Pressure > 90 or < 60. Report findings to MD if Heart Rate > 120 or < 55. Report findings to MD if O2 Saturation < 90. Report findings to MD if Blood Glucose > 350 or < 70.
HEART FAILURE:
S/O Dyspnea and/or Orthopnea.
MEDICATION MANAGEMENT:
Provide patient/caregiver/family with written and/or oral education on each medication including action, dose, side effects, interactions and adverse effects..
PAIN - R & C:
C- Assess patient pain.
RESPIRATORY STATUS:
Skilled Observation & Assessment of Respiratory Status. Skilled Observation & Assessment of Dyspnea. Teach Respiratory Disease Process.
SAFETY:
Equipment in Working Order

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Long Term Goal: Patient-stated personal goal: Medication and medical regimen compliance. Reduce binge eating.. Medication Compliant
SN: Rehab Potential is Fair For the Above Goals. Rehab Potential is Fair For the Above Goals. Rehab Potential is Fair For the Above Goals. Rehab Potential is Fair For the Above Goals
SN Discharge Plan: Discharge to Self Care With Family Community Support. Discharge to Self Care With Family Community Support. Discharge to Self Care With Family Community Support. Discharge to Self Care With Family Community Support

Clinical Summary SN: Pt is a 62-year-old male living in a Lifestream group home in Rochester. Prior to this, he was living in the community with services and supports including oversight by DDS. Due to declining cognition and worsening medical conditions, it was determined that he should live in a group home that could better support him. Client goes to church Sunday and AA on Thursdays to which staff drive him. Staff also drive client to md appts, other errands, and group outings. The group home is partially staffed with nurses at some times. We support this client in the morning only when nursing is not present. Group home nursing cares for his diabetic needs at lunch and dinner. He continues to have poor judgement and insight into disease process and medication management and is unable to manage on his own.

Interpreter Services Needed: No

Recent Hospitalizations/ER visits: none

Admission/Referral Source: Lifestream (GH)

Homebound Status: not homebound, able to leave without a taxing effort. Client walks independently out to the group home van.

Primary Diagnosis : Type 2 DM/Paranoid schizophrenia

Rationale For Services: DM2
SN continues necessary daily for med management, assessment and teaching.
Pt unable to safely manage medications due to disorganized thought process and cognitive deficits. Pt was overwhelmed living independently in the community and was placed into a Lifestream group home. MAP staff at group home administer po medications but cannot administer subcutaneous medications. Pt requires 3x daily sliding scale insulin in addition to standing doses of SQ medication.

Wounds: none

Medication Reconciliation Completed with Physician. Yes.

Medication List provided to Patient and or Caregiver in writing. Yes.

Pain in the last 5-days interfering with activity/sleep: Client does not report pain.

Depression Assessment: 0/10

Fall Risk Assessment: 3/10

Emergency Planning:
In case of inclement weather or unforeseen emergency situation when the agency staff are prevented from delivering care the agency will make every effort to see all clients. This is a priority 1 client and is seen for all visits regardless of circumstances. Client visit can only be cancelled in the event one of the Lifestream nurses is present with the pt and confirms they will be performing CBG check and insulin admin for a that visit.

Patient Rights and Responsibilities Reviewed with Patient/Caregiver. Yes.

Plan of Care Reviewed with Patient/Caregiver. Yes.

Summary of Diagnoses
Paranoid schizophrenia/Bipolar -Pt continues to struggle with mental illness, however, stable at this time on abilify, denies hallucinations and delusions and is able to CFS. Pt denies feeling depressed at this time.

Anxiety - Pt continues to struggle with bouts of anxiety. Sn continues to educate on distraction activities and slow, deep, breathing when feeling anxious.

HTN - Currently on metoprolol, isosorbide, and lisinopril daily. Pt BPs have been within MD parameters. Pt denies cardiac distress. Sn continues to educate on when to seek Emergency services, appropriate food choices and low sodium diet.

Hyperlipidemia - takes atorvastatin. Sn continues to educate on appropriate food choices and low fat diet.

DM-2 - continues on humalog insulin 3x daily SS with cov only >150, lantus bid, metformin, and farxiga. Followed by endocrinology. Client has been tolerating this regimen well with sliding scale coverage still needed. Sn continues to educate on appropriate food choices and DFC. BS ranges 70-100. Sn continues to educate on appropriate food choices and DFC.

COPD - Pt has baseline dyspnea when talking and when ambulation of 50 feet. Followed by pulmonology. Takes roflumilast.

Sleep apnea - referral to sleep medicine

Hx ETOH - sober for years, so stated, and attends AA.

Vital Signs
BS: 70 - 100
SBP ranges: 110 - 119
DBP ranges: 72 - 78
HR ranges: 71 - 85
Temp ranges: WNL

Vaccination Status
Fully vaccinated for Covid with a Booster

Participants of Care
Lifestream group home
Shannon Houlihan NP pcp
Erica Szyndlar NP cardiology
Alexis Pappas MD gi

Justin Matrisciano MD endo
Innovive Health nurses

Nurse's Signature and Date of Verbal SOC	Case Manager	Date HHA Received Signed POT
Diane Daley RN *E-Signature* 06/07/2025 @ 12:32 PM/Tara Gaskins RN 6/1/2025 @ 09:36 PM	Nicole Flechsig	(Sent 6/9/2025)

Attending Physician's Signature and Date Signed

I certify that the patient had a F2F encounter on 10/18/2022 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