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.
100009945799	11/06/2018	06/02/2025 Through 07/31/2025	13785	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

Pamplona, Donna
101 Willow St
New Bedford, MA 02740

DOB

07/27/1957

Sex

F

Directives In Place/Risk of Hospitalization

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

Risk of Hospitalization

Decline in mental, emotional, or behavioral status in the past 3 months
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

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
F20.0	Paranoid schizophrenia [ICD10]	12/23/2020 E

12. Dx Code	Surgical Procedure	Date
N/A		

13. Dx Code	Other Pertinent Diagnoses	Date
F33.9	Major depressive disorder, recurrent, unspecified [ICD10]	12/23/2020 E
E11.9	Type 2 diabetes mellitus without complications [ICD10]	11/6/2018 O
I10	Essential (primary) hypertension [ICD10]	11/6/2018 O
F41.9	Anxiety disorder, unspecified [ICD10]	11/6/2018 O
K21.9	Gastro-esophageal reflux disease without esophagitis [ICD10]	11/6/2018 O
R41.83	Borderline intellectual functioning [ICD10]	11/6/2018 O
M85.80	Other specified disorders of bone density and structure, unspecified site [ICD10]	11/6/2018 O
J45.20	Mild intermittent asthma, uncomplicated [ICD10]	11/6/2018 O
E78.5	Hyperlipidemia, unspecified [ICD10]	11/6/2018 O
F17.210	Nicotine dependence, cigarettes, uncomplicated [ICD10]	11/6/2018 O
Z79.84	Long term (current) use of oral hypoglycemic drugs [ICD10]	11/6/2018 O
Z85.3	Personal history of malignant neoplasm of breast [ICD10]	11/6/2018 O

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

Acetaminophen 325 milligram oral every 6 hours PRN Pain (take 2 tablets every 6 hours)
Prescribed By: Will, Christine A MD (Internal Medicine), 11/6/2018

atorvastatin 40 milligram oral once a day pm
Prescribed By: Will, Christine A MD (Internal Medicine), 11/6/2018

cloZAPine 500 milligram oral once a day pm for psych
Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry), 10/10/2024

Docusate Sodium 100 milligram oral 2 times a day am pm
Prescribed By: Will, Christine A MD (Internal Medicine), 11/6/2018

GuaiFENesin 10 milliliter oral every 4 hours PRN cough
Prescribed By: Will, Christine A MD (Internal Medicine), 11/6/2018

hydrOXYzine 25 milligram oral 3 times a day PRN anxiety
Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry), 12/27/2020

Maalox Advanced 10 milliliter oral 3 times a day PRN Nausea
Prescribed By: Will, Christine A MD (Internal Medicine), 11/6/2018

Magnesium Hydroxide 30 milliliter oral once a day PRN Nausea
Prescribed By: Will, Christine A MD (Internal Medicine), 11/6/2018

melatonin 5 milligram oral once a day hs
Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry), 12/27/2020

metFORMIN 500 milligram oral once a day am
Prescribed By: Will, Christine A MD (Internal Medicine), 11/6/2018

Z90.12	Acquired absence of left breast and nipple [ICD10]	11/6/2018 O	MiraLax 17 gram oral once a day am *Prescribed By: Will, Christine A MD (Internal Medicine), 11/6/2018* nystatin topical 100.000 unit topical 2 times a day PRN rash (Apply PRN to affected areas PRN) *Prescribed By: Will, Christine A MD (Internal Medicine), 11/6/2018* PriLOSEC 20 milligram oral once a day am *Prescribed By: Will, Christine A MD (Internal Medicine), 11/6/2018* RisperDAL 1 milligram oral 2 times a day am pm *Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry), 7/21/2022*

14. DME and Supplies

Gloves-unsterile, lock box, daibetic supplies

15. Safety Measures

Universal precautions

16. Nutritional Req.

No concentrated sweets

17. Allergies

sulfa drugs

18A. Functional Limitations

anxiety in which does not affect HB status

18B. Activities Permitted

No restrictions, Up as tolerated, Independent at home

19. Mental Status

Oriented, Forgetful, Depressed, Anxiety, poor insight and judgement

20. Prognosis

Guarded

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

SN: 3-5x/wk x 9 wks (6/2/2025 to 7/31/2025)
PRNx3 Complications/Med Changes
_HEAD TO TOE:
Assess Head to Toe.
_PATIENT PERSONAL PLAN:
Patient identified steps toward personal goal: Patient will cut back on the amount of cigarettes she smokes per day..
_PATIENT RISK STATUS:
Patient Risk for Emergency Room use or Hospitalization is assessed to be: Moderate and will be addressed with measures focusing on: SN to see patient BID for assessment, teaching, coordination of and medication management..
[HWC] MEDICATIONS:
Pre-pour all patients medications through next visit..
DEPRESSION:
S/O for signs/symptoms of Depression. 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: Home of a Friend. 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 of Hypo/Hyperglycemic Reactions. Skilled Observation & Assessment of Endocrine Status.
FOOT CARE:
S/O presence of skin lesions on lower extremities.
GASTROINTESTINAL:
Skilled Observation & Assessment of Elimination.
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. Medication(s) secured in lockbox for safety. Lockbox in working order..
HIGH RISK MEDICATIONS:
Provide patient/caregiver/family with written and/or oral education about high risk medications which may include meds that thin blood..
LAB/TEST:
Clozaril blood work to be drawn Monthly at child and family services, MD to monitor labs. Assess patient compliance with clozaril lab work.
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:
Teach- Interventions to monitor and mitigate pain. C- Assess patient pain.
PSYCHOSOCIAL/ENVTAL:
Teach Mental Disease Process.
RESPIRATORY STATUS:
Skilled Observation & Assessment of Respiratory Status.
SAFETY:
Skilled Observation & Assessment of Safety

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Goal: Patient-stated personal goal: Patient reports she would like to quit smoking. Medication Compliant. Early Detection & Intervention For S/SX of Complications of Disease Process/s
SN: Rehab Potential is Guarded For the Above Goals
SN Discharge Plan: Discharge to Self Care

Clinical Summary SN: Patient is a 67 year-old female who continues to live in the community with her sister. Over the course of this certification period patients elderly mother passed away. Patient continues to have no willing or able caregivers to assist her with medication management. Patients sister is unable to assist patient with medication management during the week due to her own working schedule. Patient has had no inpatient hospital admissions over the course of this certification period. Despite patients functional limitations of anxiety, depression, poor insight and judgment. Patient is not homebound. Patient leaves home on a daily basis for unlimited amounts of time without a taxing effort using public transportation to go out shopping, to go to day program, to go out with family and friends, and to go to MD appointments. Patient continues to receive skilled nursing services 5x per week for assessment, teaching, coordination of care, and medication management. Due to patients long history of mental illness patient is unable to correctly and safely self administer her own medications. She continues to have poor judgement and insight and is unable to manage on her own.

Primary Diagnosis:: Paranoid Schizophrenia

Summry of Diagnosis
Patient has a long history of mental illness (paranoid schizophrenia, depression, borderline intellectual functioning, and anxiety). Patients mood and mental status have been at patients baseline over the course of this certification period. Patient is often disengaged and makes poor eye contact. Patient can be extremely impulsive at times. Patient continues to be followed by Dr. Dolliver. Patient was last seen by Dr. Dolliver on 5/15/25 no changes made at this visit. Patient continues Risperdal 2mg QHS, Clozaril 500mg QHS, Gabapentin 100mg QAM, Melatonin 5mg QHS. Patient continues to go forroutine bloodwork for her Clozaril levels. Patinet continues to struggle with medication compliance despite medications being prepoured by skilled nurse 5x per week. Patient continues to have no knowledge of her medications despite routine teaching provided by skilled nurse. Due to patients long history of mental illness and cognitive impairment patient has poor insight and judgement regarding her present illnesses and is unable to retain information taught to her. Patient is unwilling to actively participate in administering her own medications with skilled nurse during her skilled nursing visit and continues to rely on skilled nurse to pick up her medications at the pharmacy. Patient family members continue to be unable to assist patient during the week. Skilled nurse continues to educate patient on the importance of medication compliance.

Patient has a cardiac history which includes HTN and Hyperlipidemia. Patient continues to be followed by Dr. Will for primary care. Patient denies chest pain, SOB and or headaches. Patient continues to refuse vitals during skilled nursing visits. Patient continues on Atrovasatin 40mg QPM for her hyperlipidemia. Skilled nurse continues to educate patient on the importance of compliance with a heart healthy diet. Due to patients long history of mental illness patient has poor insight and judgement and often makes poor dietary choices. Sn continues to educate on when to seek Emergency services.

Patient has a history of GERD, patient has had no GI issues over the past 60days. Patient continues on Omeprazole 20 mg daily.

Patient has asthma but has had no exacerbation of her asthma over the past 60 days. Patient continues to smoke heavily despite frequent teaching provided by skilled nurse about the negative affect smoking has on her health. Skilled nurse will continue to educate patient on the importance of actively participating in smoking cessation.

Medication Reconciliation Completed with Physician, all medications review with prescribing MDs

Medication List provided to Patient in writing, patient continues to require medication teaching and medication management due to poor insight and judgement and intellectual disabilities.

Pain Assessment, patient denies any pain at this time

Depression Assessment, patient denies any increased symptoms of depression.

Fall Risk Assessment, patient denies any recent falls.

Patient Rights and Responsibilities Reviewed with Patient, patient verbally understands

Plan of Care Reviewed with Patient, patient verbally understands and is in agreement with plan of care.

Rationale for Services
Patient continues to be seen 5x per week by skilled nurse for assessment, teaching, coordination of care and medication management. Skilled nurse administers AM PO meds and prepours meds for the remainder of the day as well as nonskilled visit days for patient to self administer. All other meds are secure in a locked box for patient safety. Ongoing skilled nursing services continue to be needed secondary to risk of decompensation related to inability to independently manage medications and disease process.

Vital Signs
Pt refuses Vital Signs and BSs despite education
Temperature Ranges during Certification Period: 97-98

Vaccination Status
Fully vaccinated for Covid

Participants of Care
Dr. Will (PCP)
Dr. Dolliver (Psych)
Caroline Manzone RN (Innvovive)

Nurse's Signature and Date of Verbal SOC	Case Manager	Date HHA Received Signed POT
Diane Daley RN *E-Signature* 06/07/2025 @ 12:18 PM/Caroline Manzone RN 6/2/2025 @ 06:10 AM	Caroline Manzone RN	(Sent 6/9/2025)

Attending Physician's Signature and Date Signed

I certify that the patient had a F2F encounter on 11/02/2018 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