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.
	06/16/2025	06/16/2025 Through 08/14/2025	6669015	227027

Physician Name and Address	Patient	DOB
Gloriane Afonso-Fede, MD Hawthorn Medical Associates 531 Faunce Corner Rd. North Dartmouth, MA 02747 (508) 996-3991 Fax (508) 961-2535	Rossi, Kari 9 Shoreview Ave Mattapoisett, MA 02739	10/28/1961 **Sex** F

Directives In Place/Risk of Hospitalization	Provider Name and Address
Proxy - Medical - Rossi, Thomas Risk of Hospitalization History of falls (2 or more falls - or any fall with an injury - in the past 12 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 Currently reports exhaustion Other Risk	Community Nurse Inc 62 Center Street Fairhaven, MA 02719 (508) 992-6278 Fax (508) 997-3091

11. Dx Code	Principal Diagnosis	Date
I69.312	Visuospatial deficit and spatial neglect following cerebral infarction [ICD10]	6/16/2025 E

12. Dx Code	Surgical Procedure	Date
N/A		

13. Dx Code	Other Pertinent Diagnoses	Date
I69.398	Other sequelae of cerebral infarction [ICD10]	6/16/2025 E
R26.81	Unsteadiness on feet [ICD10]	6/16/2025 E
B95.61	Methicillin suscep staph infct causing dis classd elswhr [ICD10]	6/16/2025 E
Z45.2	Encounter for adjustment and management of vascular access device [ICD10]	6/16/2025 E
I10	Essential (primary) hypertension [ICD10]	6/16/2025 E
D64.9	Anemia, unspecified [ICD10]	6/16/2025 E
E03.9	Hypothyroidism, unspecified [ICD10]	6/16/2025 E
F41.8	Other specified anxiety disorders [ICD10]	6/16/2025 E
Z91.81	History of falling [ICD10]	6/16/2025 E
Z79.2	Long term (current) use of antibiotics [ICD10]	6/16/2025 E
Z74.1	Need for assistance with personal care [ICD10]	6/16/2025 E

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

acetaminophen 325 mg tablet 2 tablets oral every 6 hours PRN Pain (N)
amLODIPine 10 mg tablet 1 tablets oral once a day (N)
Levothyroxine Sodium 125 mcg (0.125 mg) tablet 1 tablets oral once a day (N)
naloxone 4 mg/0.1 mL spray 1 Spray nasal once PRN Other (C)
Normal Saline Flush 10 milliliter intravenous every 4 hours (10 mls before an dafter infusion and prn for line patency. 20 ml flushes following blood draws) (N)
oxacillin 2 g/50 mL solution 2000 milligram intravenous every 4 hours (2gm delivered over 1hr every 4hrs, in between rate will be 1ml/hr (KVO) change every 24hrs at noon, til 7/4/25) (N)
oxyCODONE 5 mg tablet 0.5 tablets oral every 4 hours PRN Pain (N)

14. DME and Supplies	15. Safety Measures
Gloves-unsterile, Normal saline, PICC dressing kits, NS flushes 10cc, CAD pump, walker tub seat	Evacuation plans, Fall precautions, Fire, electric, & open flame safety, Universal precautions, Use of safety devices in bathroom

16. Nutritional Req.	17. Allergies
Regular diet	NKA

18A. Functional Limitations	18B. Activities Permitted
Ambulation, Dyspnea w/minimal exertion, Endurance	Up as tolerated, Exercise prescribed, Walker

19. Mental Status	20. Prognosis
Oriented	Good

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

SN: 3x/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

Electronically Signed by [ ] on [ ]

focusing on: Recent stroke with residual vision issues, aseptic technique with PICC med changes, picc line dressing changes, home safety. Skilled Observation & Assessment of Lung Sounds, Medication Use/Effect, 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. Fax lab results to Weekly labs CBCw/diff, CMP, liver panel and fax to Dr. ANthony Karabanow, fax # 508-992-8986 and also fax to NELC 855-810-7139, ok to use PICC for lab draws. .. S/O for signs/symptoms of Depression. S/O presence of skin lesions on lower extremities. T-Teach patient/caregiver falls risk associated with medical conditions and medications. Teach- Interventions to monitor and mitigate pain. Teach Medication Management, Medication Side Effects. Wound # 1 - Other Skin Alteration - anterior_left_antecubital_fossa - Wound # 1 - PICC

PICC dressing change weekly on Monday, monitor for s/sx of infection SN teach patient and husband what to look for.
PT: Start on 06/18/2025: 1x/wk x 1 wk, 1-2x/wk x 3 wks, 1x/wk x 5 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. C- Assess patient pain. Fall Prevention Instruction. Instruction and Progression of HEP. Patient/Caregiver Education. S/O for signs/symptoms of Depression. T-Teach patient/caregiver falls risk associated with medical conditions and medications. Teach ROM Exercises. Teach- Interventions to monitor and mitigate pain. Therapeutic Exercises/Muscle Re-education. Transfer Training. Teach Activities to Enhance Balance, Activities to Enhance Endurance, Community Ambulation, Gait Training, Home Exercise Program, Positioning to Prevent Injury, PT/SO Safe Bed Mobility, Self Monitor Symptoms/Signs, Stair Training. WBAT BLEs
OT: Start on 06/19/2025: 1x/wk x 1 wk, 1x/wk x 8 wks, PRNx2 Change in Functional Stat
Patient Risk for Emergency Room use or Hospitalization is assessed to be: Low and will be addressed with measures focusing on: ECWS/pacing ed, caregiver support, HEP, proper DME/AD setup. Adaptive/ADL Training. Assess Fine & Gross Motor Control Activities. 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. Caregiver Instruction and Training. Coordination Activities. Energy Conservation. Functional Balance training. Home Safety/Fall Prevention Training. Instruction and progression of Home Exercise Program. Muscle Re-education. Neuromuscular Education. OT Evaluation. T-Teach patient/caregiver falls risk associated with medical conditions and medications. Teach- Interventions to monitor and mitigate pain. Therapeutic Exercise. Teach Toilet Transfers, Tub Transfers
ST: Start on 06/19/2025: 1x/wk x 9 wks
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. Establish Home Management Program. Teach Compensatory Strategies, Memory Strategies, Pt/CG Nature of Disorder & HEP

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Patient Stated Personal Goal: Long Term Goal: No further sepsis and stroke symptoms. Lung sounds will be clear. Medication Compliant within cert period. Patient Stated Personal Goal- Short Term Goal: Maintain PICC line and receive ABX. Patient to be independent with blood pressure monitoring utilizing personal device. within cert period. Pt to remain safe at home as evidenced by no reported falls.. Pt/Cg will demonstrate indep management of meds within cert period. Stable CVP Status within cert period
PT Goals: Pain to L buttocks, lumbar spine will decrease down to <=2 within the next 3 weeks to allow patient improved mobility and comfort. within cert period. Patient Stated Personal Goal: Long Term Goal: Pt's goal="To walk without the walker". "Babysit my grandchildren". within cert period. Long Term Goal: Good Knowledge of Energy Conservation & Pacing Skills within cert period. Short Term Goal: Independent Chair Transfer within cert period. Short Term Goal: Independent Safe Bed Mobility within cert period. Short Term Goal: Independent With Home Exercise Program within cert period. Long Term Goal: Patient BIL Legs strength will increase >=4-/5 for easier and safer independent transfers from varied household surface heights within cert period. Long Term Goal: Patient will achieve TUG score of less than =18 seconds in order to return to independent ambulation on even surfaces without an AD to reduce risk for falls within cert period. Long Term Goal: Patient will be free from falls for 3+ weeks within cert period. Patient Stated Personal Goal- Short Term Goal: Patient will perform LE therex/ambulation program daily in two weeks time. within cert period. Pt to remain safe at home as evidenced by no reported falls. within cert period. Patient will ambulate independently for >=1000' with or without a cane to safely access the community for medical appts in 6-8 weeks time. within cert period
OT Goals: Short Term Goal: Pt to demo indep ADL demo including item setup and cleanup within cert period. Long Term Goal: Indep shower/toilet txfr with proper DME setup and no evidence of falls within cert period. Long Term Goal: Good Functional Balance within cert period. Short Term Goal: Good Understanding & Carryover of Energy Conservation Techniques within cert period. Long Term Goal: Improve Gross Motor Skills within cert period. Long Term Goal: Patient R Arm strength will increase from 3+/5 to 4/5 for easier and safer transfers/mobility and ADLs/IADLs within cert period. Patient Stated Personal Goal- Goal: Regain indep with fxnl use of RUE/hand within cert period. Pt to remain safe at home as evidenced by no reported falls.
ST Goals: Short Term Goal: Patient cognitive skills will improve from Moderate % accuracy to Mild % accuracy within cert period. Long Term Goal: Pt Will Demonstrate Improved Cognitive Skills within cert period. Goal: ST to evaluate and establish goals. within cert period

Rehab Potential is Good For the Above Goals
Discharge Plan: Discharge to Self Care With Family Community Support

Clinical Summary SN: SOC: pt had fall r/t feeling weak, and presented to ER with fever 102, dizziness, N/V, H/A, unsteady gait, right arm parenthesis. She had labs and showed MSSA bacteremia and with CVA d/t septic embolism and intracranial hemorrhage. She was put on Keppra prophylactic for 7 days. MRI of brain showed hemorrhagic lesion of bilat. Occipital with vasogenic edema and subarachnoid hemorrhage of the left parietal. She is on oxacillin 2gm every 4 hrs now was continous in hospital. PICC line place one 6/9/25, double lumen.
Primary DX: CVA d/t embolism, septicemia

PMH: HTN, hypothyroidism, anxiety/depression

COGNITION: alert and oriented x3. Pt able to recall all 3 words with cognitive assessment. S/p stroke and has right peripheral vision deficit and unsteady gait. Neurosurgeon consult recommended conservative treatment.

CARDIOVASCULAR: HR regular, h/o HTN, amlodipine increased to 10mg as they don't want her BP to be high. Pt has BP cuff at home and will check daily 2hrs after taking am medication

PULMONARY: lungs clear, denies SOB, noted slight sob with ambulation, O2 sats WNL.

BORG: 0 rest /1 activity

MOBILITY/ADL's: pt using rolling walker with all ambulation r/t back pain from fall prior to hospitalization. Pt requires assistance with all ADLs. Left PICC.

SKIN: pt skin intact with left PICC line.

PAIN: minimal back pain at time of visit. Takes Tylenol and reinforced not to take more than 3000mg in 24hr period and to avoid ASA products.

GI/GU: pt is continent of both bladder and bowels, last BM yesterday

ENDOCRINE: pt is on levothyroxine for her thyroid

DIET/NUTRITION: regular diet, good appetite

WEIGHT/ MEASUREMENTS: 5'8", 192

SAFETY: At time of visit she had no grab bars in bathroom, husband will be installing grab bars in shower, also has tub seat. Pt using RW with all ambulation. Pt has PICC line and educated on safety and avoiding pulling tubing.

MEDS: med reconciliation done with home meds and d/c summary, no discrepancies noted, no drug to drug interactions. She is on oxacillin 2gm every 4hrs with continous fluid for 24hrs, every 4 hrs will get med 48.7mls for 1 hr then KVO til next dose due.

DEPRESSION: denies

LIVING SITUATION: lives on single level home with husband,

HOMEBOUND: taxing effort to leave home r/t weakness, fatigue, pain, IV ABX/PICC, use of AD.

GOALS(Short Term and Long Term):
Short: no infection
Long: no further stroke symptom
HEALTH LITERACY: good

EMERGENCY PREPAREDNESS PLAN: plan to evacuate to Kate and Steve house in 39 Nelson Ave Fairhaven

CODE STATUS/ADVANCED DIRECTIVES: full code, HCP Husband Thomas

COMMUNITY RESOURCES: none

UPCOMING APPOINTMENTS: 6/17/25 at 130pm

REFERRALS:
SN:
PT
OT
ST

SKILL/REASON FOR HOME CARE: assess and teach med use and effectiveness, assess CVP, assess and teach PICC maintence, flushing, SASH technique, assess and teach skin integrity, s/sx of infection, home safety and fall prevention

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 patient who verbalizes understanding and agrees to participate.
PT: Physical Therapy Initial Assessment:
REASON FOR REFERRAL: Ms. Kari Rossi is a 63-year-old female who presented to a Southcoast hospital on 6/4/2025 with fevers of 102 degrees, headache, dizziness, nausea, vomiting, as well as right upper extremity paresthesia. She reports weakness and having a fall off the toilet prior to this admission. She also reports a right 5th toe bruise/discoloration of unknown etiology prior to the fall. Xray of R foot negative. WBAT B LEs. She was found to have MSSA bacteremia with CVA from aseptic emboli and intracranial hemorrhage. Brain MRI revealed bilateral occipital IPH and left parietal SAH without underlying lesion. Lumbar MRI was negative for osteomyelitis or discitis. Keppra was started BID for seizure prophylaxis x 7 days. She received IV antibiotics at hospital/rehab and continues on home IV until 7/4. She had a right peripheral vision deficit and ongoing unsteady gait. Diagnostics revealed a 3.1 cm liver lesion and right renal lesion with an outpatient liver MRI recommended. She was discharged to Spaulding Cape and Islands on 6/10/2025 for short-term rehab. She returns home with

her husband on 6/16/2025. Home PT referral for functional assessment, home safety, and strengthening.

PMH: Hypertension, hypothyroidism, depression with anxiety, obesity.

Soc HX/PLOF: She lives with her husband in a single-family, one-story ranch-style home with uneven pavers outdoors to enter through the sliding door entrance. Prior to her CVA, she was independent in the community without a device. She is a registered nurse and works part-time "subbing in the school system." She denies falls prior to her "collapse in the bathroom" prior to hospital stay. She was previously driving, doing road grocery shopping, and cleaning. Husband assists with cooking. She enjoys babysitting her grand children ages 1-4 y.o.
DME includes rolling walker, shower seat with back, long-handled shower hose newly installed.

CODE STATUS: Full code. Health care proxy is her husband, Tom.

COGNITION: Alert and oriented x3. Patient's goal: "to get off the walker." Increased response time when asked questions. ST evaluation pending.

CURRENT LEVEL OF FUNCTION: She presents sitting on a rocker recliner chair upon PT arrival. She reports 2-3/10 left lumbar and buttocks pain since falling off the toilet prior to going to the hospital. She reports that her pain is overall improving and she has not had to take oxycodone. She intermittently uses Tylenol PRN. She requires standby guard assist for supine to sit with average bed height. She requires standby guard assist for sit-to-stands and stand-step with rolling walker. She requires standby guard assist ambulating 60 ft with rolling walker, slow cadence with cues for objects on the right side due to decreased R peripheral vision. Uneven surfaces deferred today due to fatigue with in home assessment. TUG 23 with rolling walker, making her a fall risk. PT did assess ambulation without an aD with MIn-CTG A handheld amb for 50' with guarded movements and impaired balance. R 5th toe with purple fluid filled blister.

SAFETY: PT recommends use of rolling walker at this time to reduce risk for falls as well as assist for showering with husband putting together her shower seat during this session. OT evaluation pending. Supportive footwear suggested rather than use of flip flops. She is cautious about R 5th toe injury.

SKILL/REASON FOR THERAPY SERVICES: She requires skilled PT 1 to 2 times per week x 3 weeks, and then reduction to 1 time per week in order to achieve stated goals and to return to independent ambulation on both even and uneven surfaces without an assistive device.

HOMEBOUND: She is homebound as she requires assist to safely ambulate on uneven pavers and grass to/from her gravel driveway due to impaired balance reactions, right eye deficits, and decreased endurance status post CVA with bacteremia requiring IV antibiotics.

ESTIMATED # VISITS: 12

24/7 CNHC availability and red flags reviewed.

POC REVIEW: Plan of care reviewed with patient, who verbalizes understanding and agrees to participate. MD was informed of patient's plan of care. Reviewed start of care assessment.

Consent form/s reviewed with patient. Patient health care proxy verbalized understanding. This writer witnessed Kari Rossi signing the consents and form/s scanned to office.

Jennifer Young, PT OT: Skilled OT EVAL - 63-year-old female, transported to SLH (6/4/2025) with fever, headache, dizziness, n/v, & RUE paresthesia. Pt states she was experiencing weakness and fell off the toilet. WBAT BLE's. +CVA from aseptic emboli and intracranial hemorrhage. "Brain MRI revealed bilateral occipital IPH and left parietal SAH without underlying lesion. Lumbar MRI was negative for osteomyelitis or discitis. Keppra was started BID for seizure prophylaxis x 7 days. She received IV antibiotics at hospital/rehab and continues on home IV until 7/4" per RPT EVAL narrative. Right peripheral vision deficit which creates unsteady gait pattern. Pt DC to STR 6/10/2025 & returned home 6/16/2025. Skilled OT services referred to assess BUE AROM/coordination and muscle weakness, pain and fatigue with task demo, ADL/IADL participation & bathroom txfr/mobility demo with proper DME/AD setup.

PMH: HTN, Hypothyroidism, Depression with anxiety.

Soc HX/PLOF: Pt lives with spouse in SFH with uneven pavers outdoors to enter through the sliding door entrance.
PLOF - Pt was independent with fxnl txfr and mobility without AD/DME; pt denies falls & was previously indep with ADLs and IADLs.
DME includes rolling walker, shower seat with back, HHSH

CODE STATUS: FULL CODE. Health care proxy is Spouse

COGNITION: Alert and oriented (x4). Pleasant and cooperative.

CURRENT LEVEL OF FUNCTION: Patient presents with Min A Functional Transfer & Mobility demo t/o bathroom setting (with 18-inch toilet height and proper DME setup in tub). Min A required for safe UB/LB selfcare task demo. Decreased activity tolerance and increased back pain noted during task demo. Pt presents with WFL LUE AROM, 4/5 muscle strength, intact GMC/FMC and intact L hand sensation awareness. RUE strength presents as 3+/5 with decreased GMC and intact FMC during task demo / intact L hand sensation awareness. HEP is indicated to increase strength, coordination and fxnl use of RUE/hand during task and txfr demo.

SAFETY: Environment is one-level SFH with proper DME in bathroom and rolling walker for safe mobility throughout the home

setting. Patient educated on proper footwear.

SKILL/REASON FOR THERAPY SERVICES: Skilled OT services indicated to address ADL training, bathroom transfer training, fall prevention, RUE strength and coordination training.

HOMEBOUND: Patient is homebound secondary to program hospitalization with muscle weakness, decreased strength and coordination, elevated fall risk, and requires use of new rolling walker, which creates a taxing effort to leave the home setting.

ESTIMATED # VISITS: 4

24/7 CNHC availability and red flags reviewed

POC REVIEW: Plan of care reviewed with patient, who verbalizes understanding and agrees to participate. MD was informed of the patient's POC. Reviewed SOC assessment.

Consent form/s reviewed with Kari Rossi. Patient verbalized understanding. This writer witnessed Kari Rossi signing the consent form, which was scanned to the office.

Matt Germano OTR/L
ST: REASON FOR REFERRAL: Hemorraghic CVA bilateral occipital lobe and left parietal

PMH: pt had fall r/t feeling weak, and presented to ER with fever 102, dizziness, N/V, H/A, unsteady gait, right arm hemiparesis. She had labs and showed MSSA bacteremia and with CVA d/t septic embolism and intracranial hemorrhage. She was put on Keppra prophylactic for 7 days. MRI of brain showed hemorrhagic lesion of bilat. Occipital with vasogenic edema and subarachnoid hemorrhage of the left parietal. She is on oxacillin 2gm every 4 hrs now was continous in hospital. PICC line place one 6/9/25, double lumen.
Primary DX: CVA d/t embolism, septicemia

PMH: HTN, hypothyroidism, anxiety/depression

CODE STATUS: full code

COGNITION: A&Ox3, mild to moderate cognitive impairment

CURRENT LEVEL OF FUNCTION: Pt assessed with moca assessment. Pt able to converse with SLP with normal communication skills. However, given standardized assessment significant compromised function noted with visuospatial awareness and executive fx as well as impaired delayed recall and impaired thought organization. Pt also had difficulty with comprehension of longer length directions with increased language complexity. She will need tx to address deficits and improve her fx to maximize her life quality and independence.

SAFETY: fall risk, being alone for long period of time without check in

SKILL/REASON FOR THERAPY SERVICES: Pt was independent prior to fall, infection, brain hemorrhage warranting tx to address impairments to improve life quality, safety and independence.

HOMEBOUND: taxing effort to leave the home with recent cva and poor visual function, increased pain in back/buttocks due to fall, high fall risk

ESTIMATED # VISITS: 1 W 8

24/7 CNHC availability and red flags reviewed

POC REVIEW: Plan of care reviewed with pt, who verbalizes understanding and agrees to participate. MD was informed of patients POC.

Consent form/s reviewed with __pt_. Pt verbalized understanding. This writer witnessed pt signing the consents and form/s scanned to office.

Nurse's Signature and Date of Verbal SOC	Case Manager	Date HHA Received Signed POT
Deena Savage RN *E-Signature* 07/08/2025 @ 01:56 PM/Robyn DaSilva RN 6/16/2025 @ 04:53 PM	Veronica McIntosh RN	(Sent 7/9/2025)

Attending Physician's Signature and Date Signed

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**

Gloriane Afonso-Fede, MD

Electronically Signed by [ ] on [ ]