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.
	06/24/2025	06/24/2025 Through 08/22/2025	5891015	227027

Physician Name and Address	Patient	DOB
Christine A Will, MD Hawthorn Medical Associates 531 Faunce Corner Rd. North Dartmouth, MA 02747 (508) 996-3991 Fax (508) 961-2535	Lynch, Timothy 257 Walnut Plain Road Rochester, MA 02770	12/13/1977 **Sex** M

Directives In Place/Risk of Hospitalization

Proxy - Medical - Brodeur Lynch, Melissa

Risk of Hospitalization
- Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- Multiple hospitalizations (2 or more) in the past 6 months
- Multiple emergency department visits (2 or more) in the past 6 months
- 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
- 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
Z48.23	Encounter for aftercare following liver transplant [ICD10]	6/11/2025 E

12. Dx Code	Surgical Procedure	Date
N/A		

13. Dx Code	Other Pertinent Diagnoses	Date
I27.20	Pulmonary hypertension, unspecified [ICD10]	6/11/2025 E
D69.6	Thrombocytopenia, unspecified [ICD10]	6/11/2025 E
F10.21	Alcohol dependence, in remission [ICD10]	6/11/2025 E
L40.52	Psoriatic arthritis mutilans [ICD10]	6/11/2025 E
M54.50	Low back pain, unspecified [ICD10]	6/11/2025 E
G47.33	Obstructive sleep apnea (adult) (pediatric) [ICD10]	6/11/2025 E
F43.23	Adjustment disorder with mixed anxiety and depressed mood [ICD10]	6/11/2025 E
J32.9	Chronic sinusitis, unspecified [ICD10]	6/11/2025 E
K21.9	Gastro-esophageal reflux disease without esophagitis [ICD10]	6/11/2025 E
E78.5	Hyperlipidemia, unspecified [ICD10]	6/11/2025 E
R01.1	Cardiac murmur, unspecified [ICD10]	6/11/2025 E
E66.9	Obesity, unspecified [ICD10]	6/11/2025 E
Z74.1	Need for assistance with personal care [ICD10]	6/11/2025 E
Z79.2	Long term (current) use of antibiotics [ICD10]	6/11/2025 E
Z79.82	Long term (current) use of aspirin [ICD10]	6/11/2025 E
Z79.624	Long term (current) use of inhibitors of nucleotide synthesis [ICD10]	6/11/2025 E

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

acetaminophen 325 mg tablet 1 tablets oral every 8 hours PRN Mild Pain (N)
acyclovir 400 mg tablet 1 tablets oral 2 times a day (N)
Aspirin Adult EC Low Dose 81 mg delayed release tablet 1 tablets oral once a day (N)
Centrum 1 tablets oral once a day (N)
cetirizine 10 mg tablet 1 tablets oral once a day PRN ALLERGIES (N)
Docusate Sodium sodium 100 mg capsule 1 cap(s) oral 2 times a day (N)
Epoprostenol 32 milligram intravenous once a day (32ng/kg/min) (N)
furosemide 40 mg tablet 1 tablets oral 2 times a day (N)
Humira Pen 40 mg/0.4 mL kit 40 milligram subcutaneous every other week (ON HOLD!) (N)
Melatonin 10 mg tablet 1 tablets oral once a day hs PRN Sleep (N)
mycophenolate mofetil 500 mg tablet 1 tablets oral 2 times a day (Swish and swallow 5mL with breast, with lunch and dinner) (N)
nystatin 100000 units/mL suspension 5 milliliter oral 4 times a day (N)
oxyCODONE 5 mg tablet 1 tablets oral every 6 hours PRN Moderate Pain (N)
pantoprazole 40 mg delayed release tablet 1 tablets oral once a day (BEFORE BREAKFAST) (N)
Senna 8.6 mg tablet 2 tablets oral once a day hs (N)
sulfamethoxazole-trimethoprim 400 mg-80 mg tablet 1 tablets oral once a day (N)
tacrolimus 1 mg capsule 3 cap(s) oral every 12 hours (C)
tadalafil 20 mg tablet 2 tablets oral once a day (N)
ursodiol 300 mg capsule 1 cap(s) oral 3 times a day (N)

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Z87.891	Personal history of nicotine dependence [ICD10]	6/11/2025 E
Z86.19	Personal history of other infectious and parasitic diseases [ICD10]	6/11/2025 E

14. DME and Supplies	15. Safety Measures
Normal saline, Sterile 4x4s, Tape HHSH, handicap height toilet	Bleeding precautions, Evacuation plans, Fall precautions, Fire, electric, & open flame safety, No ambulation w/o assist, Universal precautions
16. Nutritional Req.	**17. Allergies**
Regular diet	SEASONAL
18A. Functional Limitations	**18B. Activities Permitted**
Ambulation, Endurance	Up as tolerated, Exercise prescribed
19. Mental Status	**20. Prognosis**
Oriented	Good

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

SN: 1x/wk x 1 wk, 1x/wk x 8 wks, PRNx4 Exacerbation of Disease P
Patient Risk for Emergency Room use or Hospitalization is assessed to be: High and will be addressed with measures focusing on: Risk of rejection, teach s/s of infection, C/P assessment, BP and HR management, education on medication use and side effects, safety and fall prevention, edema management, wound care.. Skilled Observation & Assessment of Cough/Sputum, Dyspnea, Incision Line, Integument Status, Lung Sounds, Nutrition/Hydration, Vital Signs. 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. C-Interventions for treatment of depression. 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. Teach- Interventions to monitor and mitigate pain. Teach Energy Conservation With Activity, Management of Constipation, Management of Diarrhea, Medication Side Effects, Medication Use. Wound # 1 - Surgical - anterior_right_upper_abdominal_quadrant - Wound #1- Surgical to RUQ- LOTA. Please assess at every visit- 19 staples noted.. Wound # 2 - Surgical - anterior_right_lower_abdominal_quadrant - Wound #2- Surgical (removed drain site) to RLQ- Cleanse with NS, pat dry, apply gauze followed by medifix tape- to be changed daily- patient can perform on non-SN days.. Wound # 3 - Surgical - anterior_right_lower_abdominal_quadrant - Wound #3- Surgical (removed drain site) to RLQ- Cleanse with NS, pat dry, apply gauze followed by medifix tape- to be changed daily- patient can perform on non-SN days.. Wound # 4 - Surgical - anterior_right_lower_abdominal_quadrant - Wound #4- Surgical (removed drain site) to RLQ- Cleanse with NS, pat dry, apply gauze followed by medifix tape- to be changed daily- patient can perform on non-SN days.. GENERAL SURGEON: Doctor James Pomposelli (Tufts)
Veleteri: Doctor Harrison Farber (Tufts)
Transplant Coordinator: Doctor Almacdotti. patient has continuous epoprostenol via IV pump through R chest port-a-cath. Patient changes dressings weekly and PRN (next dressing change is Saturday). He changes medication cassettes independently every day. He receives port-a-cath dressings and cassettes through Accredo Specialty Pharmacy.
PT: Start on 06/25/2025: 1x/wk x 1 wk, 1x/wk x 8 wks, PRNx4 Change in Functional Stat
balance/coordination 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. Balance training focused on strength issues. C- Assess patient pain. Fall Prevention Instruction. Home Safety Evaluation. S/O for signs/symptoms of Depression. Teach ROM Exercises. Teach- Interventions to monitor and mitigate pain. Therapeutic Exercises/Muscle Re-education. Teach Breathing Technique/Exercise, Gait Training, Home Exercise Program, Pacing & Energy Conservation Techniques, PT/SO Safe Bed Mobility, Stair Training. Transfer training
OT: Start on 07/02/2025: 1x/da x 1 da
OT evaluation declined by patient
Diet: Start on 06/25/2025: Once every 14 das x 14 das
Dietician visit pending

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Patient will be able to teach back 3 signs/symptoms of wound infection within 3 weeks. within 3 wks. Pt to remain safe at home as evidenced by no reported falls.
PT Goals: Patient Stated Personal Goal: Long Term Goal: To return to working full time as a fire fighter within 8 wks. Long Term Goal: Pt to demonstrate improved standing balance as evident with improved Tinetti score of >/= 22/28 within 6 wks. Long Term Goal: The patient will demonstrate improved functional lower extremity strength by improving 30 second sit to stand score to 15 to allow patient to progress to safe/I transfers at various surfaces in the home without AD within 8 wks. Patient Stated Personal Goal- Short Term Goal: Pt to perform B LE HEP sitting/supine/standing 2-3 time/day and hourly amb in home with assist as tolerated within 3 wks. Pt to remain safe at home as evidenced by no reported falls.. Pt to demonstrate I with fall prevention techniques within 4 wks. Pt to demonstrate improved B LE strength of 3+/5- 4-/5 in order to allow for improved cadence/step height/length/heel strike/push off to enable pt to progress to safe/I amb even surfaces in the home without AD within 8 wks. Pt to demonstrate improved standing balance & decreased fall risk as evident with TUG time of OT Goals: OT evaluation declined by patient
Diet Goals: Dietician visit pending

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

Clinical Summary SN: ***Prior to recent hospitalization- In January 2025, patient started with SOB. Patient went to Tobey hospital but was shipped to Tufts Medical. Patient noted to have pulmonary artery HTN caused by portal HTN most likely

caused by cirrhosis of the liver. During that hospitalization, patient received a R chest port for veletri. Patient has to change cassette daily and change dressing weekly.

SOC: Timothy Lynch is a 47-year-old male admitted to Tufts Medical Center from 6/11 to 6/23 for alcoholic cirrhosis of the liver without ascites. Patient underwent DDLT on 6/12/25 and post-op was admitted to SICU. Labs concerning for mild AKI with response to fluid resuscitation. Post-op course further C/B ileus and nausea/vomiting- NG tube placement on 6/15 he was kept on a CLD. Chest tube was removed on 6/16 after demonstrating clinical improvement and lack of need for ICU services. Patient was transferred to the floor on 6/16. Patient had BM on 6/16 and passed a clamp trial on 6/17. He had a complete return of bowel function and was able to tolerate normal diet. He had persistent high output from drains but his H+H remained stable. He received albumin boluses to maintain fluid status. Labs are notable for thrombocytopenia 29k. On 6/20 drain 1 and 3 removed with sutures placed. He had a transient increase in bilirubin but has begun to downtrend. On 6/22 Hickman Catheter was noted to no longer be attached to the skin by sutures. He was tolerating a regular diet and pain was well controlled with oral meds, was ambulating with minimal assistance, voiding spontaneously and was deemed safe for discharge.

Primary DX: Alcoholic cirrhosis of the liver without ascites requiring transplant

PMH: Alcohol use disorder, elevated LFTs, heart murmur, obstructive sleep apnea, psoriasis, pulmonary hypertension, shortness of breath, thrombocytopenia, tobacco dependence in remission, adjustment disorder with mixed anxiety and depression, chronic sinusitis, GERD, hepatic cirrhosis, hyperlipidemia, low back pain, Lyme disease.

COGNITION: A+O x 3

CARDIOVASCULAR: HR 99 apical and regular, BP: 102/50 (has been baseline for patient). +2 pitting edema noted to BLE. Denies chest pain/pressure/palpitations.

PULMONARY: O2 sat RA: 96%. Lung sounds clear. He denies cough, sputum production.

BORG: Borg at rest depends on positioning due to abdomen size status post surgery, but he denies shortness of breath with exertion.

MOBILITY/ADL's: patient ambulates without an AD. He has a slow gait s/p surgery and increase in edema to BLE. Patient's sister to assist with ADLs/IADLs. Patient declined need for PT/OT/HHA.

SKIN: +2 pitting edema noted to BLE. Patient has a long surgical incision with 19 staples. He also has 3 drain removal sites that are stuured. Abdomen with bruising due to surgery and heparin shots. Patient declined need for full skin assessment. He has a R chest port that is accessed for infusion. Patient independently changes dressing to Port-a-cath site and he changes cassette for infusion daily without issue.

PAIN: Patient has 6/10 pain to abdomen. He took Oxycodone 5 mg last night and Tylenol 500 mg one tab this morning with good effect. He understands to pick up tylenol 325mg.

GI/GU: denies s/s of UTI. Denies urinary/fecal incontinence. Last BM: 6/24- abdomen slightly rounded s/p surgery, +BS. Patient reports diarrhea most likely due to infusion- he continues to take senna and docusate sodium as ordered but he will ask MD at next visit on Thursday if he needs to take constipation medication. SN reviewed he can lose essential electrolytes and become dehydrated with diarrhea so he understands to increase fluid intake.

ENDOCRINE: N/A

DIET/NUTRITION: Patient reports "I am hungry but I don't want to eat." SN placed referral for dietitian.

MEDS: SN reconciled medications using Tufts Medical Discharge paperwork- no med discrepancies noted. Patient receives tidalefil, infusion medication and port dressings from Accredo pharmacy. He gets all other medications from CVS in Target in Wareham. Patient feels comfortable to take medications independently. Patient no longer taking carvedilol due to hypotension and no longer taking omeprazole since he is on pantoprazole.

DEPRESSION: denies

LIVING SITUATION: patient lives in a two story home but main bathroom and bedroom are on main floor. He usually lives with his spouse but his sister will be taking care of him at this time.

HOMEBOUND: taxing effort to leave home, requires frequent rest periods, fatigues easily, increase risk for infection due to recent surgery.

GOALS: (Short Term and Long Term): short term goal: improve appetite and decrease swelling, long term goal: stop infusion.

HEALTH LITERACY: low to moderate

EMERGENCY PREPAREDNESS PLAN: patient to stay in his home (has generator)

CODE STATUS/ADVANCED DIRECTIVES: Full Code, HCP is spouse.

COMMUNITY RESOURCES: N/A

UPCOMING APPOINTMENTS: 6/26: Transplant Surgical Consultation, 6/30: Transplant Surgical Consultation, 7/7: Transplant Surgical Consultation, 7/14 Transplant Surgical Consultation, 7/16 Support Staff, 7/31 Transplant follow-up visit with Katie

Moeller PA

REFERRALS:
SN:
TELEMED:

SKILL/REASON FOR HOME CARE: wound care, teach s/s of infection, C/P assessment, BP and HR management, education on medication use and side effects, safety and fall prevention, edema management.

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.

Consent form/s reviewed with patient. Pt/HCP verbalized understanding. This writer witnessed patient signing the consents and form/s scanned to office/filed in medical record.
PT: REASON FOR REFERRAL: Patient is a 47 y/o male referred to CN PT following hospitalization 06/11/2025-06/23/2025. Primary diagnosis: alcoholic cirrhosis of liver without ascites, s/p liver transplant. Patient is referred to CN PT to assess gait, mobility, home safety, and strength. Pt reports he doesn't know if he'll be able to "do anything with you today," reports drainage recently began from recently sutured abdominal drainage site, pt has contacted his "transplant team," and is awaiting return call. Pt declines need for CN RN visit today.

PMH: OSA, psoriasis, per pt - low back sx 2024, 2020 R knee sx

Soc HX/PLOF: Patient lives in a two-story SFH with 1 STE f/b 2 STE no railings present outside plus 1 threshold step no railing with his spouse; there are 2 steps inside no railing between mud room/home. Pt reports 2nd floor of home is never accessed. Patient's sister is currently assisting patient with his care. Pt reports prior to being hosp he was I with all his mobility without AD, driving, working as fire fighter full time, I with ADL/IADLs.
DME in home is HHSH, handicap height toilet

CODE STATUS: Full code. HCP spouse.

COGNITION: A & Ox3.

CURRENT LEVEL OF FUNCTION: Pt declined to attempt bed mobility d/t drainage recently started from sutured drain site abdomen
Transfers limited by increased time/effort, requires use of B UE, wide BOS depending upon seat height requiring SB/vc'ing
Gait deviations include without AD even surface in home, head down, slightly decreased cadence/step height/heel strike/push off/B UE arm swing requiring SB/vc'ing
Pt demonstrates decreased B LE ROM/strength as evident with ROM/MMT. Pt declined to attempt 30 sec chair stand test d/t drainage recently started from sutured drain site abdomen
Pt demonstrates decreased standing balance & increased fall risk as evident with Tinetti score of 18/28
Pt declined to attempt TUG d/t drainage recently started from sutured drain site abdomen

SAFETY: 3 large dogs in home, dog toys/beds/blankets on floor, s/p hosp 06/11/2025-06/23/2025, primary diagnosis: alcoholic cirrhosis of liver without ascites, s/p liver transplant, decreased B LE ROM/strength/balance/cardio pulmonary capacity/safety awareness, increased fall risk, post op pain/fatigue/edema, requires narcotics for pain relief, requires AD/assist of one for all transfer/amb tolerating even surfaces/short distances only, requires assist of one for bed mobility, requires assist of one to amb on STE with AD, multiple co morbidities, requires frequent sitting rests

SKILL/REASON FOR THERAPY SERVICES: Skilled PT is necessary to address these B LE ROM/strength/bed mobility/transfer/gait/balance/cardiopulmonary capacity/safety deficits. Without skilled PT, patient is at increased risk of falls with injury, re hospitalization, increased dependence upon caregivers for assist with mobility, and decreased quality of life. Skilled PT is expected to return patient's mobility to PLOF.

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ESTIMATED # VISITS: 6

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 patient's POC. Reviewed SOC assessment.

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Maureen Graca, PT

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Maureen Graca, PT

Nurse's Signature and Date of Verbal SOC	Case Manager	Date HHA Received Signed POT
Jill Ott RN *E-Signature* 07/01/2025 @ 01:19 PM/Marissa Cappola RN 6/24/2025 @ 07:54 PM	Marissa Cappola RN	(Sent 7/2/2025)

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**

Christine A Will, MD

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