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.
9NU3UN5PG89	06/10/2025	06/10/2025 Through 08/08/2025	3320011	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

Werly, Bonnie L
239 Cross Rd
Autumn Glen at Dartmouth Apt 219
Dartmouth, MA 02747

DOB

06/16/1939

Sex

F

Directives In Place/Risk of Hospitalization

DNR
Proxy - Medical - Borges, Robyn

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
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
E10.65	Type 1 diabetes mellitus with hyperglycemia [ICD10]	6/10/2025 E

12. Dx Code	Surgical Procedure	Date
N/A		

13. Dx Code	Other Pertinent Diagnoses	Date
I10	Essential (primary) hypertension [ICD10]	6/10/2025 E
R42	Dizziness and giddiness [ICD10]	6/10/2025 E
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy [ICD10]	6/10/2025 E
K31.84	Gastroparesis [ICD10]	6/10/2025 E
E10.21	Type 1 diabetes mellitus with diabetic nephropathy [ICD10]	6/10/2025 E
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified [ICD10]	6/10/2025 E
K86.89	Other specified diseases of pancreas [ICD10]	6/10/2025 E
E83.52	Hypercalcemia [ICD10]	6/10/2025 E
N39.41	Urge incontinence [ICD10]	6/10/2025 E
N28.1	Cyst of kidney, acquired [ICD10]	6/10/2025 E
M41.86	Other forms of scoliosis, lumbar region [ICD10]	6/10/2025 E
M54.30	Sciatica, unspecified side [ICD10]	6/10/2025 E
E78.5	Hyperlipidemia, unspecified [ICD10]	6/10/2025 E
I25.2	Old myocardial infarction [ICD10]	6/10/2025 E
Z87.440	Personal history of urinary (tract) infections [ICD10]	6/10/2025 E
Z87.891	Personal history of nicotine dependence [ICD10]	6/10/2025 E

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

acetaminophen 325 mg tablet 2 tablets oral every 6 hours PRN Pain (N)
Acidophilus - capsule 1 cap(s) oral once a day (N)
atorvastatin 40 mg tablet 1 tablets oral once a day (N)
celecoxib 200 mg capsule 1 cap(s) oral 2 times a day (N)
ergocalciferol 50,000 intl units capsule 1 cap(s) oral once a week (N)
famotidine 20 mg tablet 1 tablets oral 2 times a day (N)
gabapentin 100 mg capsule 1 cap(s) oral 3 times a day (N)
HumaLOG 4 - 16 unit subcutaneous 3 times a day (Taken before meals Sliding scale 150-200=4 units 201-250=6 units 251-300=8 units 301-350=10 units 351-400=12 units 401-450=14 units 451-500=16 units)
DC Ordered By: Qin, Shan MD (Nephrology), (N)
Lantus 100 units/mL solution 12 unit subcutaneous once a day pm
DC Ordered By: Qin, Shan MD (Nephrology), (N)
Lantus 100 units/mL solution 24 unit subcutaneous once a day am
DC Ordered By: Qin, Shan MD (Nephrology), (N)
Losartan Potassium 50 mg tablet 1 tablets oral once a day (N)
melatonin 3 mg tablet 1 tablets oral once a day hs PRN Other (For insomnia) (N)
melatonin 3 mg tablet 2 tablets oral once a day PRN Other (For insomnia) (N)
MiraLax - powder for reconstitution 17 gram oral once a day PRN Constipation (N)
Norvasc 10 mg tablet 1 tablets oral once a day (N)
polyethylene glycol 3350 - powder for reconstitution 17 gram oral 2 times a day (N)
Senna Plus 50 mg-8.6 mg tablet 2 tablets oral once a day (N)
Senna Plus 50 mg-8.6 mg tablet 3 tablets oral once a day PRN Constipation (N)

14. DME and Supplies

RW

15. Safety Measures

Fall precautions, Universal precautions, Use of safety devices in bathroom

16. Nutritional Req.

1800 ADA diet

17. Allergies

levoFLOXacin, acetaminophen-oxycodone, loperamide, lisinopril, lincomycin, erythromycin, clindamycin, ciprofloxacin, ampicillin, sulfur containg compound, penicillins

Electronically Signed by [ ] on [ ]

18A. Functional Limitations	18B. Activities Permitted
Bowel/Bladder (Incontinence), Endurance, Legally blind	Up as tolerated, Walker
19. Mental Status	**20. Prognosis**
Oriented	Fair

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

SN: 1x/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: High and will be addressed with measures focusing on: continuing assessment/teaching, pain management, med use/effect, home safety/fall prevention, skin integrity maintenance, infection prevention, blood sugar monitoring, and nutrition.. Skilled Observation & Assessment Blood Sugar per home glucose monitoring. Call Physician for BS below 70 or above 500, Blood Sugars Per Home Glucose Monitoring Report blood sugar greater than 500, Endocrine Status, GU Status, Integument Status, Lung Sounds, Medication Use/Effect, Nutrition/Hydration, S/SX UTI, Safety, 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- Assess use and effectiveness of prescribed medications. DO NOT RESUSCITATE. Provide education to Patient on diabetic foot care including monitoring for the presence of skin lesions on the lower extremities. 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 Management of Urinary Incontinence, Medication Side Effects, Medication Use, Perineal Hygiene
PT: Start on 06/13/2025: 1x/wk x 1 wk, 1x/wk x 8 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. Energy Conservation/Endurance Activities. Fall Prevention Instruction. Home Safety Evaluation. Instruction and Progression of HEP. Pain Management Instruction/Education. Patient/Caregiver Education. Therapeutic Exercises/Muscle Re-education. Transfer Training. Teach Activities to Enhance Balance, Activities to Enhance Endurance, Body Mechanics, Gait Training, Home Exercise Program. Heat Application for 20 minutes to L Shoulder; provide treatments PRN for pain 5 times a day

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Patient Stated Personal Goal: Long Term Goal: I want to get stronger within cert period. Medication Compliant within cert period. Patient Stated Personal Goal- Short Term Goal: I would like to lower my blood sugar within cert period. Patient will be compliant with the use of pain meds. within cert period. Patient/CG will be able to teach back 3 signs/symptoms of urinary tract infection within 2 weeks within cert period. Pt to remain safe at home as evidenced by no reported falls. within cert period. Pt/CG will be able to teach back 2 pressure relief interventions within 2 weeks in order to maintain skin integrity. within cert period. Pt/Cg will demonstrate indep management of meds within cert period. Safety In Home within cert period
PT Goals: Long Term Goal: Patient will increase Posture, step length, pace and HS in order to ambulate 300 ft level with RW with indep with reports of pain 0-4/10 to be able to allow pt to safely negotiate ALF and access dining area. Long Term Goal: Patient will improve Scoot to edge of surface and anterior weight shift in order to perform sit to stand with RW with indep to allow pt to safely access toilet, chair and bed.. Patient Stated Personal Goal: Short Term Goal: Pt will be indep recall and demo HEP. Patient Stated Personal Goal- Long Term Goal: I want to walk better in the ALF and not require an escort

SN: Rehab Potential is Fair For the Above Goals
PT: 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: SOC: Pt is an 85 y.o. Female who was having routine bloodwork done on 5/7/25 and starting complaining of dizziness and "feeling like BP was low." EMS was called and pt taken to SLH ED. Pt and her daughter denied any acute neurologic changes. Pt reported she had started a new insulin (tresiba) a few days prior and noticed increasing dizziness. Pt blood sugar 236. Pt noted to have demand ischemia with minimally elevated troponins. Pt also noted to have orthostatic hypotension. Pt was admitted for observation. MRI brain done and was negative. Pt reports her Zanaflex was d/c as it could be contributing to dizziness. Pt discharged to Alden Court for STR on 5/13/25. Pt then discharged back to Autumn Glenn on 6/9/25 with referral to CNHC for SN, PT, and OT.

SN witnessed pt sign all consent forms. Forms scanned to office.

Primary DX: Dizziness, hyperglycemia

PMH: Spinal stenosis, scoliosis, neuropathy, DM, near blindness in left eye, HTN, HLD, recurrent UTI, arthritis, renal cyst.

COGNITION: A+Ox4.

CARDIOVASCULAR: Pt denies chest pain or pressure. BP 128/74 sitting and 122/72 standing (not orthostatic). HR 72 and regular. No edema noted.

PULMONARY: LS clear throughout. O2 sat 97% on RA. Due to increased weakness and deconditioning, pt noted to have SOB with moderate exertion. SN encouraged pt to take rest breaks as needed with activity to prevent overexertion and SOB and decrease risk of falls.

BORG: 0 at rest. 1-2 with activity.

MOBILITY/ADL's: Pt ambulates with an unsteady gait using a RW. Pt still complaining of some ongoing dizziness, more notable when standing. SN encouraged pt to stand slowly and not ambulate if feeling dizzy as it can increase risk of falls. Pt also reports she has decreased ROM on her left shoulder due to her arthritis. She states she is due for a cortisone injection. Due to increased weakness, increased pain, and increased SOB, pt has decreased tolerance for activity. Pt has assistance from staff at

Autumn Glenn for ADLs. Pt agreeable to PT eval but declines need for OT eval at this time. SN placed t/c to PCP to inform.

SKIN: No skin alterations noted.

PAIN: Pt reports 8/10 generalized aching/stiffness r/t to arthritis. Pt states the pain is often worse with movement. She manages pain with Celebrex BID and Tylenol as needed with fair effect.

GI/GU: Pt reports she is incontinent and has a history of recurrent UTI. SN discussed importance of good perineal hygiene to decrease risk of UTIs. Pt also states she has a history of constipation which she manages with Miralax and Senna. Last BM 6/10/25. BS X4 Abdomen soft and non-tender.

ENDOCRINE: Pt with DM Type 2. Her DM was previously being managed by her PCP. Pt now has appointment to see Glynelle White, NP on 6/23. Pt with Freestyle Libre glucometer. Blood sugar 306 at time of SN visit. Pt reports her blood sugars are often above 300. Pt currently on sliding scale insulin with a Humalog pen along with Lantus BID. Pt informed to report if blood sugar is above 500.

DIET/NUTRITION: Pt follows a diabetic diet. She states she has a good appetite. All meals are prepared by staff at Autumn Glenn.

WEIGHT/ MEASUREMENTS: 163 at time of SN visit.

SAFETY: Pt is at increased risk for falls due to her increased weakness, advanced age, dizziness, and near blindness in left eye. Pt reports she cannot see very well out of the left eye and everything is black and white. Pt has some clutter in the home with obstructs walking paths. She has a tub seat and grab bars. She also has a power recliner.

MEDS: Med rec completed using Alden Court med list. Pt daughter, Robyn, manages all medications and prefills pt med box. SN attempted to call Robyn to review med list. Awaiting return call.

DEPRESSION: PHQ 0. Pt is in a pleasant mood and happy to be home.

LIVING SITUATION: Pt lives at Autumn Glenn.

HOMEBOUND: There is a severe and taxing effort to leave the home secondary to increased weakness and deconditioning, unsteady gait, increased fall risk, increased pain, increased SOB, and decreased endurance.

GOALS:
Short term: I would like to lower my blood sugar
Long term: I want to get stronger

HEALTH LITERACY: Fair

EMERGENCY PREPAREDNESS PLAN: In place

CODE STATUS/ADVANCED DIRECTIVES: DNR per MOLST. HCP is daughter, Robyn Borges.

COMMUNITY RESOURCES: N/A

UPCOMING APPOINTMENTS:
6/19/25 at 8:40- Paula Walsh NP
6/23/25 at 10- Glynelle White, NP

REFERRALS:
SN:
PT
Palliative- Pt states she spoke with someone liaison in the hospital about palliative care. She states that given her age and comorbidities, she would like palliative care evaluation.

SKILL/REASON FOR HOME CARE: There is an ongoing need for continuing assessment/teaching, pain management, med use/effect, home safety/fall prevention, skin integrity maintenance, infection prevention, blood sugar monitoring, and nutrition.

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 Bonnie who verbalizes understanding and agrees to participate.
PT: REASON FOR REFERRAL: Patient was taken to St. Luke's Hospital Emergency Department and diagnosed with hyperglycemia and orthostatic hypotension. Patient was admitted from 5/7/25 to 5/13/25. Patient was transferred to Alden Court on 5/13/25 and discharged home on 6/9/2020.

PMH: Spinal stenosis, scoliosis, neuropathy, diabetes mellitus, blindness in left eye, hypertension, hyperlipidemia, recurrent UTIs, arthritis, renal cyst, and chronic hyperglycemia.

Soc HX/PLOF: Patient is an 85-year-old female living in assisted living with no stairs to enter/exit and elevator access to the second floor. Patient has the following equipment: rolling walker, bed rail, shower chair, grab bars, wheelchair, and single point cane. Patient was independent in the community with a rolling walker PLOF.

COGNITION: A & O x 3

CURRENT LEVEL OF FUNCTION: Pt is indep sit-supine with bed rail. Patient is standby assist sit to stand to the RW with decreased anterior weight shift dependence on the lift chair and increased dependence on RUE. Pt is SBA amb 100 ft level with decreased pace, decreased step length, and decreased heel strike.

SAFETY: fall risk

SKILL/REASON FOR HOMECARE: Patient centered goal: "I want to be able to get around the ALF better." Pt is functioning below PLOF. Pt c/o pain low back 0/10-7/10, and L shoulder 0/10-10/10. Pt scored a 0 with 30s chair stand score. Pt scored a 30.7 TUG. The pt is at high risk for falls. If pt does not receive skilled PT the pt will likely be hosp in 30-90 days. Pt requires skilled PT for gait training, balance training, transfer training, pain management, therex, stair training, strengthening and pt ed

HOMEBOUND:yes, SBA amb 100 ft level RW. Pt only leaves home for MD appts. Pt trips out of the home are of short duration and are infrequent in nature. When pt returns home from trips out of ALF, she requires multiple hour rest period to recover.

ESTIMATED # VISITS:

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 POC. Reviewed SOC assessment.

Consent form/s reviewed with patient. Pt/HCP verbalized understanding. This writer witnessed Bonnie Werly signing the consents and form/s scanned to office.

Nurse's Signature and Date of Verbal SOC	Case Manager	Date HHA Received Signed POT
Christine O'Donnell RN *E-Signature* 07/01/2025 @ 02:38 PM/Amanda Paul RN 6/10/2025 @ 02:40 PM	Sheri Braga RN	(Sent 7/2/2025)

Attending Physician's Signature and Date Signed

I certify that the patient had a F2F encounter on 05/28/2025 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 [ ]