HW4850118FoMGVY7JJAP

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.
100022221756	09/12/2016	05/28/2025 Through 07/26/2025	7864	140111

Physician Name and Address

Gloriane Afonso Fede, MD
535 Faunce Corner Rd
North Dartmouth, MA 02747
(508) 996-3991 Fax (000) 000-0000

Patient

Pierce, Gary J
182 state street
3rd Floor
New Bedford, MA 02740

DOB

07/14/1967

Sex

M

Directives In Place/Risk of Hospitalization

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

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
F20.9	Schizophrenia, unspecified [ICD10]	9/12/2016 O

12. Dx Code	Surgical Procedure	Date
N/A		

13. Dx Code	Other Pertinent Diagnoses	Date
F32.9	Major depressive disorder, single episode, unspecified [ICD10]	9/12/2016 O
F39	Unspecified mood [affective] disorder [ICD10]	9/12/2016 O
I10	Essential (primary) hypertension [ICD10]	9/12/2016 O
K21.9	Gastro-esophageal reflux disease without esophagitis [ICD10]	9/12/2016 O
Z79.899	Other long term (current) drug therapy [ICD10]	9/12/2016 O
K64.9	Unspecified hemorrhoids [ICD10]	9/13/2016 O
E78.5	Hyperlipidemia, unspecified [ICD10]	9/13/2016 O
F17.200	Nicotine dependence, unspecified, uncomplicated [ICD10]	9/13/2016 O

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

acetaminophen 500 milligram oral every 8 hours PRN Other (Prn pain/fever)
Prescribed By: Afonso Fede, Gloriane MD (Internal Medicine), 7/13/2018

amLODIPine 10 milligram oral once a day hs
Prescribed By: Afonso Fede, Gloriane MD (Internal Medicine), 5/9/2023

atorvastatin 10 milligram oral once a day am
Prescribed By: Afonso Fede, Gloriane MD (Internal Medicine), 4/16/2021

Clozaril 375 milligram oral once a day hs for Other (Start on 2/16/23 After one day of clozapine 350mg)
Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry), 2/15/2023

Docu Soft 100 milligram oral 2 times a day am hs
Prescribed By: Afonso Fede, Gloriane MD (Internal Medicine), 2/9/2024

hydroCHLOROthiazide 25 milligram oral once a day am (New script due to combo tablet with losartan on back order.)
Prescribed By: Afonso Fede, Gloriane MD (Internal Medicine), 3/10/2022

hydrOXYzine 25 milligram oral every 12 hours PRN Other (PRN ANXIETY. Can take 2 tablets at night for sleep (50 mg total) if needed.)
Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry), 1/19/2022

ibuprofen 600 milligram intravenous every 4 hours PRN Pain (From er for pain in toe on r foot)
Prescribed By: Afonso Fede, Gloriane MD (Internal Medicine), 8/14/2023

Lexapro 20 milligram oral once a day am (20 mg in AM)
Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry),

11/25/2024
losartan 100 milligram oral once a day am
Prescribed By: Afonso Fede, Gloriane MD (Internal Medicine), 6/8/2022
One A Day Men's Complete 1 cap(s) oral once a day am (Patient self manages)
Prescribed By: Afonso Fede, Gloriane MD (Internal Medicine), 10/30/2024
polyethylene glycol 3350 17 gram oral once a day (Patient self manages)
Prescribed By: Afonso Fede, Gloriane MD (Internal Medicine), 10/30/2024
Potassium Chloride ER 10 mEq capsule, extended release 10 milliequivalents oral once a day
Prescribed By: Afonso Fede, Gloriane MD (Internal Medicine), 5/25/2025 (N)
propranolol 10 milligram oral once a day hs (QHS. Hold for BP below 100/60.)
Prescribed By: Czarnota Dolliver, Lucyna MD (Psychiatry), 1/20/2024

14. DME and Supplies

Gloves-unsterile, Lock Box

15. Safety Measures

Bleeding precautions, Fire, electric, & open flame safety, Hand railings, Medication confusion, Universal precautions

16. Nutritional Req.

Lo Na, Low cholesterol diet, Low fat diet, No salt added diet

17. Allergies

NKA

18A. Functional Limitations

Anxiety/depression of which does not affect HB status

18B. Activities Permitted

No restrictions, Up as tolerated, Independent at home

19. Mental Status

Oriented, Forgetful, Depressed

20. Prognosis

Fair

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

SN: Once every da x 60 das (5/28/2025 to 7/26/2025)
PRNx3 Complications/Med Changes
_HEAD TO TOE:
Assess Head to Toe.
_PATIENT PERSONAL PLAN:
Patient identified steps toward personal goal: Adhere to low sodium diet.
_PATIENT RISK STATUS:
Patient Risk for Emergency Room use or Hospitalization is assessed to be: Moderate and will be addressed with measures focusing on: SNV to continue for assessment, education, medication management, and to promote safety.
[HWC] MEDICATIONS:
Pre-pour all patients medications thorugh next visit. Administer Medications as per physician orders.
DEPRESSION:
C-Interventions for treatment of depression. S/O of effectiveness of psychotropic medications. S/O for signs/symptoms of Depression.
EMERGENCY PREPAREDNESS:
In the event of an emergency or natural disaster, the patient prefers to evacuate to: Evacuation Location - Address Acushnet ave, nb Evacuation Location - Phone 774-202-7901. The patient requires life saving equipment of: Med box. In the event of a power outage the patient has access to: N/A.
GENERAL:
Skilled Observation & Assessment of Vital Signs. Report findings to MD if Systolic Blood Pressure > 160 or < 90. Report findings to MD if Diastolic Blood Pressure > 95 or < 50. Report findings to MD if Heart Rate > 120 or < 59.
LAB/TEST:
CLOZARIL LABS DUE QMonthly, CBC done monthly - remind patient
Last competed : 3/2/25
Next due :4/2/25.
MEDICATION MANAGEMENT:
Provide patient/careagiver/family with written and/or oral education on each medication including action, dose, side effects, interactions and adverse reactions.
PAIN - R & C:

Assess patients pain.
PSYCHOSOCIAL/ENVTAL:
Skilled Observation & Assessment of Psych/Social Needs. Assist client in identifying ways to investigate the validity of plausible (although unlikely) beliefs that he/ she has: substantiate reality, as the client tends to discount or misinterpret it.
Assess Anxiety.
SAFETY:
Skilled Observation & Assessment of Safety. T-Teach patient/caregiver falls risk associated with medical conditions and medications

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Goal: Patient-stated personal goal: Eat healthy. Pt would like to quit smoking
SN: Rehab Potential is Fair For the Above Goals
SN Discharge Plan: Patient will be discharged when they are able to manage medications and disease process independently.

Clinical Summary SN: Patient is a 57 year old male living independently in low income housing in New Bedford. Patient is alert and oriented x4 and independent with ADLS but continues to need daily snv for medication management and medication compliance. Patient has no willing or able caregivers to assist with disease process and medication management. He continues to have poor judgement and insight and is unable to manage on his own.

Interpreter Services Needed: n/a

Recent Hospitalizations/ER visits: none during Recert period

Admission/Referral Source: Dr. Dolliver hawthorn medical

Homebound Status: no, patient is not homebound. Patient hs active unrestricted drivers license and is able to walk short distances with little to no taxing effort

Primary Diagnosis: Schitzophrenia

Rationale For Services
Schitzophrenia- Patient has a long history of struggling with his mental health. Patient becomes easily overwhelmed with complicated medication regimen and during medicaiton prepour gets overwhelmed with education due to amount of medications. Despite sn education patient unable to recall daily medications by name or appearance. Patient also continues to need monthly lab work for monitoring on clozaril levels and will not go unless prompted by sn. During this recertification period patient has had a few instances of medication non compliance with night time medications when he doesn't have snv. Patient at high risk for medication non compliance leading to rapid decompensation

Wounds: n/a

Medication Reconciliation Completed with Physician. Yes

Medications were reconciled with the physician who approved them. Yes

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

Pain in the last 5-days interfering with activity/sleep: patient denies

Depression Assessment: patient denies depression and anxiety, denies si/hi and verbally CFS.

Fall Risk Assessment: none during Recert period

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. Patients Category 2 and above have been provided with an updated pre-poured medication sleeve and have been educated on how to use it. The patient has also been educated on how to contact the agency or access emergency services.

Patient's Rights and Responsibilities Reviewed with Client/Caregiver. Yes

Plan of Care Reviewed with the Patient/Caregiver. Yes

The plan of care was reviewed and established with the Patient/caregiver. Yes

Summarize each pertinent diagnosis
Schitzophrenia- patient continues to need ongoing snv for education regarding medicaiton regimen and importance of compliance. During medicaiton prepours patient often times becomes overwhelmed with amount of medications and will get up and go to the bathroom or make breakfast during teaching. Patient verbalizes understanding but unable to recall daily medicaitons based off name or appearance. Last month, patient almost missed his clozaril lab work and said "it's fine I'll get it done next month". Sn reiterated strict compliance with medication labs in order to ensure medication refills. Patient continues to need reinforcement regarding indication of labs and correlation with med refills. Patient pharmacy changes during this recertification period due to patient not picking up refills stating "the pharmacy is too far". Ongoing snv continue to focus on daily medication regimen, indications for medications and s/s of decompensation due to medication non compliance.

MDD: Pt continues to struggle with bouts of depression, however, denies at this time. Pt denies SI/HI and is able to CFS.

HTN: Pt BPs fluctuated throughout the recert period. Pt denies Cardiac distress. Sn continues to educate on when to seek Emergency services, appropriate food choices and low sodium diet.

Goal Progression: patient continues to progress slower than anticipated towards goals of independence

Vital Signs
SBP ranges: 122-168
DBP ranges: 70-104
HR ranges: 76-118
Temp ranges: 96.5-98.0

Vaccination Status
Fully vaccinated for Covid

Participants of Care
Dr. Alfonso- PCP
Dr. Dolliver- psych
Cardiology- hawthorn medical pending initial patient appt
Innovive health VNA

Nurse's Signature and Date of Verbal SOC	Case Manager	Date HHA Received Signed POT
Diane Daley RN *E-Signature* 06/02/2025 @ 07:09 PM/Sarah Victorino RN 5/28/2025 @ 05:41 AM	Sarah Victorino RN	(Sent 6/3/2025)

Attending Physician's Signature and Date Signed

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**

Gloriane Afonso Fede, MD