HW485011J3T9TXHCQF8D

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. |
|---|---|---|---|---|
| 100012143937 | 11/07/2024 | 07/05/2025 Through 09/02/2025 | 457 | 227504 |

**Physician Name and Address**

Shan Qin, MD
537 Faunce Corner Road- DA ONLY
NPI #1891138822
Dartmouth, MA 02747
(508) 996-3991 Fax (508) 961-0876

**Patient**

Varela, Manuel
241 county st
New Bedford, MA 02740

**DOB**

02/08/1969

**Sex**

M

**Directives In Place/Risk of Hospitalization**

Proxy - Legal - Rodrigues, francisco

Risk of Hospitalization

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
Other Risk

**Provider Name and Address**

Guardian Home Health Care, LLC
750 West Center St
3rd Floor
W Bridgewater, MA 02379
(508) 588-5811
Fax (508) 588-5221

| 11. Dx Code | Principal Diagnosis | Date |
|---|---|---|
| E11.43 | Type 2 diabetes mellitus with diabetic autonomic (poly) neuropathy [ICD10] | 4/24/2025 E |

| 12. Dx Code | Surgical Procedure | Date |
|---|---|---|
| N/A | | |

| 13. Dx Code | Other Pertinent Diagnoses | Date |
|---|---|---|
| K31.84 | Gastroparesis [ICD10] | 4/24/2025 E |
| K59.89 | Other specified functional intestinal disorders [ICD10] | 4/24/2025 E |
| F20.0 | Paranoid schizophrenia [ICD10] | 11/7/2024 E |
| I10 | Essential (primary) hypertension [ICD10] | 11/7/2024 E |
| E66.01 | Morbid (severe) obesity due to excess calories [ICD10] | 11/7/2024 E |
| Z68.41 | Body mass index (BMI) 40.0-44.9, adult [ICD10] | 11/7/2024 E |
| Z79.84 | Long term (current) use of oral hypoglycemic drugs [ICD10] | 11/7/2024 E |
| Z79.4 | Long term (current) use of insulin [ICD10] | 11/7/2024 E |

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

acetaminophen 650 milligram oral every 6 hours PRN pain, temp> 100
amLODIPine 5 mg tablet 1 tablets oral once a day (Adm in Am. Prescribed by Paula Walsh)
atenolol 50 mg tablet 1 tablets oral 2 times a day (Hold for Bp < 100/60)
Basaglar KwikPen 100 units/mL solution 10 unit subcutaneous once a day (N)
Depakote 500 mg delayed release tablet 1 cap(s) oral 2 times a day
*Prescribed By: Czarnota Dolliver, Lucyna MD, 6/20/2025* (N)
docusate-senna 50 mg-8.6 mg tablet 1 tablets oral once a day (At bedtime)
Farxiga 10 mg tablet 1 tablets oral once a day
*Prescribed By: Cardoza, Gabriella M NP (Nurse Practitioner), 11/7/2024*
glipiZIDE 5 mg tablet 1 tablets oral once a day
*Prescribed By: Cardoza, Gabriella M NP (Nurse Practitioner), 11/7/2024*
guaiFENesin 100 mg/5 mL liquid 10 milliliter oral every 4 hours PRN cough (200 mg)
Haldol Decanoate decanoate 50 mg/mL solution 50 milligram intramuscular every 2 weeks
Iron with Vitamin C 65/125mg tablets oral once a day (On hold until further notice per endocrinology NP Gabriella Cardoza)
*Prescribed By: Cardoza, Gabriella M NP (Nurse Practitioner), 5/2/2025*
lubiprostone 24 mcg capsule 1 cap(s) oral 2 times a day
Maalox Regular Strength 10 milliliter oral 3 times a day PRN indigestion (One hour after a meal)
melatonin 3 mg tablet 1 tablets oral once a day hs

metFORMIN 1000 mg tablet 1 tablets oral 2 times a day (Am and pm)
*Prescribed By: Cardoza, Gabriella M NP (Nurse Practitioner), 11/7/2024*
Milk of Magnesia 30 milliliter oral once a day PRN constipation (At bedtime)
MiraLax - powder for reconstitution 17 gram oral once a day (Dissolve in 8 oz of water daily at bedtime per Dr. Barakat)
MiraLax - powder for reconstitution 17 gram oral once a day PRN Constipation (Take if no BM in 2 days and must be 8 hours apart from scheduled hs daily dose per Dr. Barakat)
OLANZapine 30 milligram oral once a day (At bedtime)
*Prescribed By: Czarnota Dolliver, Lucyna MD, 5/9/2025*
pravastatin 20 mg tablet 1 tablets oral once a day (Prescribed by Paula Walsh)
sertraline 100 mg tablet 1 tablets oral once a day
tamsulosin 0.4 mg capsule 1 cap(s) oral once a day (Q AM)

14. DME and Supplies

Gloves-unsterile

15. Safety Measures

Blood and body fluid prec., Evacuation plans, Fire, electric, & open flame safety, Medication confusion, Needle disposal precautions, Universal precautions

16. Nutritional Req.

No concentrated sweets

17. Allergies

NKA

18A. Functional Limitations

N/A

18B. Activities Permitted

No restrictions

19. Mental Status

Oriented, Forgetful, Depressed, Agitated

20. Prognosis

Fair

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

SN: 5-7x/wk x 10 wks, PRNx1 Complications/Med Changes
_HEAD TO TOE:
Assess Head to Toe.
_PATIENT PERSONAL PLAN:
Patient identified steps toward personal goal: doesn't have a goal.
_PATIENT RISK STATUS:
Patient Risk for Emergency Room use or Hospitalization is assessed to be: Moderate and will be addressed with measures focusing on: Daily GI assessment, teaching and encouraging pt to report S/SX. Educate patient and caregivers on measures to assist in infection prevention (hand-washing, avoid touching face, limit contact with those who are sick, cover mouth when coughing) and early signs and symptoms that need to be reported.
[HWC] MEDICATIONS:
C-Monitor the effectiveness of drug therapy, drug reactions, and side effects.
DEPRESSION:
S/O for signs/symptoms of Depression.
ENDOCRINE STATUS:
Skilled Observation & Assessment of Hypo/Hyperglycemic Reactions. Skilled Observation & Assessment of Blood Sugars Per Home Glucose Monitoring .. Skilled Observation & Assessment of Endocrine Status. Administer Insulin As Ordered. Teach S/SX Prevention, Treatment of Hypo/Hyperglycemia. Teach Skin & Foot Care. Teach Endocrine Disease Process.
ENT:
Teach Diet.
GASTROINTESTINAL:
Skilled Observation & Assessment of Elimination. Skilled Observation & Assessment of GI Status. Teach Gastrointestinal Disease Process.
GENERAL:
Skilled Observation & Assessment of Vital Signs. Sn to assist patient with blood glucose monitoring and administer insulin daily as prescribed.. Administer haldol deconate intramuscular injection as prescribed every 2weeks.. Report findings to MD if Systolic Blood Pressure > 160 or < 100. Report findings to MD if Diastolic Blood Pressure > 90 or < 60. Report findings to MD if Heart Rate > 110 or < 60. Report findings to MD if O2 Saturation < 90. Report findings to MD if Blood Glucose > 450 or < 70. LPN supervision done every 30 days. This agency is allowed to receive orders from other healthcare providers

involved in the care of this patient or another provider working in the same practice as myself, in my absence..
INTEGUMENT STATUS:
Skilled Observation & Assessment of Integument Status.
MED ADMIN VISIT:
Medications tolerated well. Prep/Admin Insulin. Assess Medication S/E. Patient is compliant with Medications. Patient is unable to Self-administer injectable due to Impaired cognitive, behavioral, emotional issues.
MEDICATIONS:
Skilled Observation & Assessment of Medication Use/Effect. Teach Medication Side Effects. C-Inform Physician and reconcile significant medication issues. Educate patient/caregiver on high risk medications.
NEURO STATUS:
Skilled Observation & Assessment of Mental Status.
PAIN - R & C:
C- Assess patient pain. T-Teach principles of pain management.
PSYCHOSOCIAL/ENVTAL:
Teach Coping/Problem Solving Strategies. Teach Mental Disease Process.
SAFETY:
Skilled Observation & Assessment of Safety. Teach Home Safety

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Long Term Goal: Patient-stated personal goal: "I can't think of one". Medication Compliant within cert period. Early Detection & Intervention For S/SX of Complications of Disease Process/s

Rehab Potential is Fair For the Above Goals
Discharge Plan: Care is needed for indefinite period of time alternative care is more costly

Clinical Summary SN: Pt is a 56 year male, resides in group home as pt cannot safely and reliably live independently without risking decompensation and hospitalization. Pt has PMH of diabetes type 2, gastroparesis, gastrostomy, paranoid schizophrenia, HTN and morbid obesity, recurrent bowel obstructions requiring hospitalization interventions. Pt presents alert and oriented X 3, pleasant mood during, answering questions appropriately but difficult to engage in conversation, poor eye contact, dull affect, guarded stance. Pt reports mood as tolerable, baseline anxiety and depressive feelings, pt has history of paranoid schizophrenia, denies alteration of thoughts at time of visit. Pt reports sleeping adequate, appearance appropriate. Abd distended and firm, central obesity, baseline for patient, + BS on all quads, pt denies any discomfort , Nausea or vomiting. Pt reports last bowel movement yesterday morming. LSCTA, denies shortness of breath or respiratory distress, short of breath with moderate exertion. Pt is continent of bowel and bladder, positive pedal pulses and csm. Pt is independent with activities of daily living, bathing and dressing. Pt able to prepare light meals with staff supervision. Pt attends social day program daily with encouragement. Pt cannot safely and reliably manage treatment plan and medications. Group Home staff med certified, however, not authorized to administer injections and only manages pts oral medications. Pt requires sn services to remain safe in the community and prevent decompensation or hospitalization. Pt recently had increase in haldol decimate frequency, new order to adm haldol detonate 50 mgevery two weeks per Dr Dolliver, pt cannot self administer intramuscular injection. Pt requires sn for daily insulin injections, as pt cannot safely and reliably prepared and refuses to self administer, monitoring of disease process and management, bowel care and regime, Medications teaching and monitoring for potential side effects, nutrition and diabetes management and safety and fall prevention. Pt requires ongoing daily education and encouragement to follow plan of care and reports changes in condition for prompt treatment plan. Pt is not homebound and leaves at will for unlimited periods of time to go shopping and social gatherings. Pt reports feeling safe at time of visit.

| Nurse's Signature and Date of Verbal SOC | Case Manager | Date HHA Received Signed POT |
|---|---|---|
| Larisa London RN *E-Signature* 07/03/2025 07/03/2025 @ 01:06 PM | Paula Rutch RN | (Sent 7/3/2025) |

Attending Physician's Signature and Date Signed

I certify/recertify that this patient is not 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

SignatureX Electronically Signed by [ ] on [ ] DateX

Shan Qin, MD