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.
100010733218	06/10/2025	06/10/2025 Through 08/08/2025	6593015	227027

Physician Name and Address	Patient	DOB
Raju Singla, MD Prima Care 289 Pleasant St. Suite 601 Fall River, MA 02721 (508) 679-5888 Fax (508) 679-1059	Costa, Diane 569 Middle St Apt 2 Fall River, MA 02724	01/24/1957 **Sex** F

Directives In Place/Risk of Hospitalization

Proxy - Medical - Javier, Heidi

Risk of Hospitalization
- History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- 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
K83.09	Other cholangitis [ICD10]	5/28/2025 E

12. Dx Code	Surgical Procedure	Date
N/A		

13. Dx Code	Other Pertinent Diagnoses	Date
J43.9	Emphysema, unspecified [ICD10]	6/10/2025 E
K21.00	Gastro-esophageal reflux disease with esophagitis, without bleeding [ICD10]	6/10/2025 E
K75.81	Nonalcoholic steatohepatitis (NASH) [ICD10]	6/10/2025 E
F41.1	Generalized anxiety disorder [ICD10]	6/10/2025 E
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris [ICD10]	6/10/2025 E
I70.8	Atherosclerosis of other arteries [ICD10]	6/10/2025 E
E78.5	Hyperlipidemia, unspecified [ICD10]	6/10/2025 E
M81.0	Age-related osteoporosis without current pathological fracture [ICD10]	6/10/2025 E
R91.8	Other nonspecific abnormal finding of lung field [ICD10]	6/10/2025 E
R59.1	Generalized enlarged lymph nodes [ICD10]	6/10/2025 E
R63.4	Abnormal weight loss [ICD10]	6/10/2025 E
Z91.81	History of falling [ICD10]	6/10/2025 E
Z87.11	Personal history of peptic ulcer disease [ICD10]	6/10/2025 E
Z90.49	Acquired absence of other specified parts of digestive tract [ICD10]	6/10/2025 E

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

Fluticasone Propionate 50 mcg/inh spray 1 Spray nasal once a day (N)
Fluticasone Propionate Diskus 250 mcg/inh powder 1 inhalation inhalation 2 times a day (N)
loratadine 10 mg tablet 1 tablets oral once a day (N)
pantoprazole 40 mg delayed release tablet 1 tablets oral once a day (N)
Proventil HFA 90 mcg/inh aerosol 2 inhalation inhalation every 4 hours PRN Shortness of Breath (N)
ursodiol 250 mg tablet 1 tablets oral 3 times a day (N)
Vitamin B1 100 mg tablet 2 tablets oral once a day (N)
Vitamin D2 50,000 intl units capsule 1 cap(s) oral once a week (N)
Xifaxan 550 mg tablet 1 tablets oral 2 times a day (N)

14. DME and Supplies

Walker

15. Safety Measures

Fall precautions, Universal precautions

16. Nutritional Req.

17. Allergies

Regular diet	NKA
18A. Functional Limitations	**18B. Activities Permitted**
Ambulation, Dyspnea w/minimal exertion, Endurance	Up as tolerated, Walker
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 Complications/Med Changes
Patient Risk for Emergency Room use or Hospitalization is assessed to be: Moderate and will be addressed with measures focusing on: Teach safety, med use, pain management. Skilled Observation & Assessment of Dyspnea, GI Status, Nutrition/Hydration. 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. T-Teach Interventions to prevent pressure ulcers. T-Teach patient/caregiver falls risk associated with medical conditions and medications. Teach- Interventions to monitor and mitigate pain. Teach Cough & Deep Breath, Home Safety, Hydration, Medication Management, Medication Use, S/SX Resp. Infection
PT: Start on 06/15/2025: 1x/wk x 8 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. C- Assess patient pain. Fall Prevention Instruction. Instruction and Progression of HEP. Patient/Caregiver Education. Teach Functional Mobility. Teach Activities to Enhance Endurance, Body Mechanics, Community Ambulation, Gait Training, Home Exercise Program, Home Safety, Pacing, Stair Training
OT: Once every 14 das x 14 das
OT Evaluation
Diet: Once every 14 das x 14 das
Diet Eval

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Long Term Goal: Patient-stated personal goal: "Get stronger". Pt/CG will be able to teach back 2 pressure relief interventions within 2 weeks in order to maintain skin integrity.. Safety In Home
PT Goals: Patient Stated Personal Goal- Goal: " get stronger / do my exercises " within cert period. Patient will ambulate 1 x 500 feet on even and uneven surfaces with LRD independently to allow access to community services. within cert period. Patient will increase activity tolerance to 15 minutes in standing to allow for completion of functional tasks. within cert period. Patient will be independent with fall prevention/safety awareness techniques to reduce fall risk with functional mobility. within cert period. Patient will ascend/descend 9 outdoor stairs with railing independently to allow entrance to /egress from home. within cert period. Patient will increase strength by 1/2 grade throughout to improve functional mobility skills on all surfaces. within cert period. Patient will improve TUG score to less than 13.5 seconds and improve Tinetti score to 24/28 to demonstrate reduced fall risk with mobility . within cert period
OT Goals: Goal: OT to evaluate and establish goals.
Diet Goals: Diet Eval

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

Clinical Summary SN: SOC: 68 y/o female reports she had several week of diarrhea and was then found on the floor of her apartment 5/21, sent to SAH. Patient transferred to RIH 5/22 dx cholangitis, underwent ERCP with stent placement. dc home on 6/8. Patient referred to outpatient liver clinic @ RIH.

Primary DX: cholangitis

PMH: anxiety, migraines, falls

COGNITION: alert and oriented

CARDIOVASCULAR: HR regular, denies dizziness or chest pain

PULMONARY: lungs clear, denies cough or congestion. Sob with mod exertion

BORG: 0/10 at rest

MOBILITY/ADL's: unsteady, weak and deconditioned, using a walker. Reports daughter assisting with ADLS. Per referral BES was in place prior to hospitalization, awaiting re-eval from CM. Patient declining MSW or HHA at this time.

SKIN: warm/dry, denies concerns. Bruising from IV insertion and blood draws noted to BUE

PAIN: reports some joint aching r/t lack of mobility during hospitalization

GI/GU: denies s/x UTI, denies NVD GI upset or constipation reports BMs "almost back to normal"

ENDOCRINE: n/a

DIET/NUTRITION: reports fair PO intake, states she lost a lot of weight in the past 2 months due to her illness. Gets MOW. Agreeable to RD eval

WEIGHT/ MEASUREMENTS: unable to safely weigh

SAFETY: at risk for falls, infection

MEDS: reviewed meds with patient, no discrepancies noted. Patient to f/u with PCP regarding her PRN Ativan, advised it was DCd in hospital. Pt verbalized understanding.

DEPRESSION: denies

LIVING SITUATION: lives alone in first floor apartment. Family nearby assist as needed

HOMEBOUND: unsteady gait, fall risk, sob with exertion, aching joints

GOALS(Short Term and Long Term): improved mobility and endurance, knowledge of meds and disease process

HEALTH LITERACY: low

EMERGENCY PREPAREDNESS PLAN: patient to remain @ home

CODE STATUS/ADVANCED DIRECTIVES: full code, reports daughter is HCP no copy in the home

COMMUNITY RESOURCES: BES, MOW

UPCOMING APPOINTMENTS: patient to call PCP and liver clinic for f/u appts ASAP

REFERRALS:
SN:
PT
OT
DIET

SKILL/REASON FOR HOME CARE: teach/assess safety, med use, pain management, skin care, nutrition/hydration, disease process, s/x to report, community resources.

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: PT EVALUATION:

Reason for Referral: Patient seen this date for PT evaluation. Results as noted. Patient is a 68 year old female who was found on kitchen floor by her brother and taken to SAH on 5/21/25 where she was transferred to RIH on 5/22/25. Patient was diagnosed with and treated for cholangitis and DC home on 06/09/25.

Primary DX: cholangitis, ERCP

PMH: chronic airway obstruction, acid reflux, liver disease, anxiety

COGNITION: alert and oriented x 3

ADV DIRECTIVE/CODE STATUS: HCP - Heidi Javier- daughter

SOC HX/PLOF: Pt lives alone in first floor apartment with turtle with approx 9 stairs with bil railing to enter/exit home via front entrance. Patient reports independent mobility without device prior to admission. Granddaughter present throughout

CURRENT LEVEL OF FUNCTION: Patient presents with decresaed standing dynamic balance, decreased strength BLE, decresaed safety awareness, and decreased activity tolerance resulting in decreased functional mobility skills on all surfaces with increased fall risk

BED MOBILITY: Performed supine <> sit transfers (sleeps on couch) independently without difficulty

TRANSFERS: Performs sit <> stand transfers from recliner, standard chair, toilet, and bed independently

GAIT: Patient ambulated 4 x 25 feet on even in home without device and close supervision followed by 1 x 50 feet with rolling walker and supervision. Patient amb with decreased step length, decreased amb tolerance, and min decreased postural awareness

MMT: RLE hip 4-/5 , knee 4/5, ankle 4+/5
LLE hip 4-/5 , knee 4/5 ,ankle 4/+5

ROM. : BLE wfl actively throughout BLE

SAFETY: MAHC- 10 = 30 sec STS = 10 Tinetti = 14/28 indicating increased fall risk

SKILL/REASON FOR HOMECARE: Skilled PT is necessary to address decreased strength BLE, decreased activity tolerance, decreased standing dynamic balance, and decreased functional mobility skills on all surfaces in order to return to PLOF with reduced risk for falls and debility, as well as provide safety education and education on compensatory strategies for residual

impairments.

HOMEBOUND: Patient is homebound secondary decreased activity tol/ decreased mobility skills. Patient requires assist of one person/walker to leave home along with leaving home is a considerable taxing effort

ESTIMATED # VISITS: 4 visits

24/7 CNHC availability and red flags reviewed

POC REVIEW: Plan of care reviewed with patient/granddaughter who verbalizes understanding and agrees to participate. MD was informed of patient's POC.

Consent form reviewed with patient. Patient verbalized understanding. This writer witnessed patient signing the consent and form scanned to office.

See PT assessment for further clinical details.

KManchester PT, DPT

Nurse's Signature and Date of Verbal SOC	Case Manager	Date HHA Received Signed POT
Christine O'Donnell RN *E-Signature* 06/23/2025 @ 03:11 PM/Casey Sullivan RN 6/10/2025 @ 02:09 PM	Casey Sullivan RN	(Sent 6/25/2025)

Attending Physician's Signature and Date Signed

I certify that the patient had a F2F encounter on 06/08/2025 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**

Raju Singla, MD