HW485011J3T9TXHCM83M

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.
100031947029	06/04/2024	05/30/2025 Through 07/28/2025	554005	227504

Physician Name and Address

Robert J Caldas, MD
531 Faunce Corner Road
NPI #1124032883
Dartmouth, MA 02747
(508) 996-3991 Fax (508) 961-0949

Patient

Velez-Morales, Yomayra
1959 Purchase St
Apt E303
New Bedford, MA 02740

DOB

10/26/1975

Sex

F

Directives In Place/Risk of Hospitalization

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

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

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
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease [ICD10]	6/4/2024 E

12. Dx Code	Surgical Procedure	Date
N/A		

13. Dx Code	Other Pertinent Diagnoses	Date
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny [ICD10]	6/4/2024 E
N18.31	Chronic kidney disease, stage 3a [ICD10]	6/4/2024 E
F32.2	Major depressive disorder, single episode, severe without psychotic features [ICD10]	6/4/2024 E
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy [ICD10]	6/4/2024 E
K59.00	Constipation, unspecified [ICD10]	6/4/2024 E
Q05.7	Lumbar spina bifida without hydrocephalus [ICD10]	6/4/2024 E
M81.0	Age-related osteoporosis without current pathological fracture [ICD10]	6/4/2024 E
M41.9	Scoliosis, unspecified [ICD10]	6/4/2024 E
E66.9	Obesity, unspecified [ICD10]	6/4/2024 E
Z96.41	Presence of insulin pump (external) (internal) [ICD10]	6/4/2024 E
E03.9	Hypothyroidism, unspecified [ICD10]	6/4/2024 E

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

alendronate 70 mg tablet 1 tablets oral once a week (On Wednesdays)
amLODIPine 10 mg tablet 1 tablets oral once a day
busPIRone 30 mg tablet 2 tablets oral once a day (At HS)
famotidine 20 mg tablet 1 tablets oral once a day (Bedtime)
Fluticasone Propionate 50 mcg/inh spray 2 Spray nasal once a day (To each nostril)
hydrOXYzine pamoate 100 mg capsule 2 tablets oral once a day (HS)
Insulin Lispro 100 units/mL solution up to 150 unit subcutaneous continuous (use with insulin pump based on carbs being consumed)
levothyroxine 200 mcg (0.2 mg) tablet 1 tablets oral 6 times a week (Before breakfast mon - Saturday)
levothyroxine 200 mcg (0.2 mg) tablet 2 tablets oral once a week (Before breakfast Sundays only)
lisinopril 5 mg tablet 1 tablets oral once a day
Mupirocin 2% ointment 1 application topical 3 times a day (To top of Left foot until finished)
omeprazole 20 milligram oral 2 times a day (Before meals)
propranolol 10 mg tablet 1.5 tablets oral once a day PRN anxiety (C)
rosuvastatin 5 mg tablet 1 tablets oral once a day
Seroquel 200 mg tablet 1 tablets oral once a day (At bedtime)
TraZODone Hydrochloride 100 mg tablet 2 tablets oral once a day (200 mg At bedtime)
Ventolin HFA 90 mcg/inh aerosol 2 puffs inhalation every 4 hours PRN Wheezing, SOB

Z79.4	Long term (current) use of insulin [ICD10]	6/4/2024 E

14. DME and Supplies

N/A

15. Safety Measures

Evacuation plans, Fall precautions, Needle disposal precautions, Universal precautions, Use of safety devices in bathroom

16. Nutritional Req.

Low cholesterol diet, No salt added diet, No concentrated sweets

17. Allergies

empagliflozin, metFORMIN, sulfamethoxazole-trimethoprim

18A. Functional Limitations

Ambulation, Endurance

18B. Activities Permitted

Walker

19. Mental Status

Oriented, Forgetful, Depressed

20. Prognosis

Fair

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

SN: 1x/wk x 1 wk, 1-3x/wk x 9 wks
_HEAD TO TOE:
Assess Head to Toe.
_PATIENT PERSONAL PLAN:
Patient identified steps toward personal goal: Compliance with POC which includes, taking meds A/O, attending appointments.
_PATIENT RISK STATUS:
Patient Risk for Emergency Room use or Hospitalization is assessed to be: Moderate and will be addressed with measures focusing on: medication compliance, MD follow up, recognizing symptoms of disease exacerbation. 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.
[HWC] MODALITIES:
Stabilization brace to L Leg ON AM, off HS.
[HWC] PAIN:
Pain management focused on positioning.
[HWC] SAFETY-ENVIRONMENT:
Safety management focused on emergency exit plan.
ADL/MOBILITY:
Skilled Observation & Assessment of Gait.
CARDIOVASCULAR STATUS:
S/O of Cardiovascular Status.
DEPRESSION:
S/O - use of psychotropic medications. T-Teach importance of taking medications as prescribed. S/O for signs/symptoms of Depression. Assess for suicidal ideation.
ENDOCRINE STATUS:
Skilled Observation & Assessment of Blood Sugars Per Home Glucose Monitoring Assess insulin pump Q visit
Check BS log Q visit. Skilled Observation & Assessment Blood Sugar per home glucose monitoring. Call Physician for BS below 60 or above 450. Skilled Observation & Assessment of Endocrine Status. Teach Skin & Foot Care. Teach Endocrine Disease Process.
GENERAL:
Skilled Observation & Assessment of Vital Signs. SN prepares and administers medication Q visit, assess compliance and effectiveness, prepares meds to last till the next SN visit .. 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..
GU STATUS:
Teach Perineal Hygiene.
INTEGUMENT STATUS:
Skilled Observation & Assessment of Integument Status.
MEDICATIONS:
Teach Medication Management. C-Inform Physician and reconcile significant medication issues. C-Monitor the effectiveness of drug therapy, drug reactions, and side effects.
PAIN - R & C:
C- Assess patient pain. T-Teach principles of pain management.

RESPIRATORY STATUS:
Skilled Observation & Assessment of Lung Sounds.
SAFETY:
Teach Home Safety

22. Goals/Rehabilitation Potential/Discharge Plans

SN Goals: Long Term Goal: Patient-stated personal goal: Not get hospitalized within cert period. The Patient and Caregiver will demonstrate decreased fall risk as evidenced by no falls. within cert period. The patient will experience less interfering pain as evidenced by improved activities of daily living within cert period. The Patient and Caregiver will demonstrate decreased environmental safety risk as evidenced by emergency exit plan. within cert period. Maintain Or Increase Function, Strength, & Endurance within cert period. Patient Will Demonstrate Optimal Glucose Control Through Diet within cert period. Medication Compliant within cert period. Safety In Home within cert period

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

Nurse's Signature and Date of Verbal SOC	Case Manager	Date HHA Received Signed POT
Marta Luban RN *E-Signature* 05/26/2025 05/28/2025 @ 11:14 AM	Joyce Kimani RN	(Sent 5/28/2025)

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

Signature**X** Date**X**

Robert J Caldas, MD