

Patient Information

Patient's HI Claim No. --	Start of Care Date 04/24/2025	Certification Period From: 04/24/2025 To: 06/22/2025		Medical Record No. MA240918073804
Patient's Name and Address Martins, Carminda 170 Sycamore St New Bedford, MA 02740		Gender Female	Date of Birth 07/14/1938	Phone Number (774) 305-3390
		Email --		Primary Language English

Patient Risk Profile

Risk Factors: 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(s) not listed in 1-8.

Clinical Data

Clinical Manager AFONSO, MELISSA	Branch Name and Address Nightingale Visiting Nurses 125 County ST. Taunton, MA 02780-3561	Phone Number (508) 967-0761
Provider Number - Medicare Number 1881923936		Fax Number (508) 967-0767

Primary Diagnosis

Code J18.9	Description Pneumonia, unspecified organism (O)	Date 04/24/2025
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Secondary/Other Diagnosis

Code I12.9	Description Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny ()	Date 04/24/2025
N18.31	Chronic kidney disease, stage 3a ()	04/24/2025
M15.9	Polyosteoarthritis, unspecified ()	04/24/2025
E78.49	Other hyperlipidemia ()	04/24/2025
H26.9	Unspecified cataract ()	04/24/2025
Z98.890	Other specified postprocedural states ()	04/24/2025

Mental Status**Orientation:**

Person: Oriented. Time : Oriented.
Place : Oriented. Situation: Oriented.

Memory: Forgetful.

Neurological: No problems.

Mood: Appropriate (WNL).

Behavioral: Appropriate (WNL).

Psychosocial: Patient has helpful daughter (PCA).

Additional Information: --

DME & Supplies

Cane. walker.

Prognosis

Good

Clinician: Clinician, Agency

Signature:

Date: 7/1/2025

Safety Measures

Keep Pathway Clear. Instructed on disaster/emergency plan. Instructed on mobility safety. Support During Transfer and Ambulation. Emergency Plan Developed. Instructed on safe utilities management. Safety in ADLs. Instructed on safety measures. Fall Precautions. Use of Assistive Devices. Standard Precautions/Infection Control. , Triage/Risk Code: 3/3, Disaster Code: 3

Nutritional Requirements

Regular. Heart Healthy. Low Cholesterol.

Functional Limitations

Bowel/Bladder Incontinence, Endurance, Dyspnea, Ambulation, Hearing

Other

--

Activities Permitted

Exercise prescribed, Cane, walker

Other

--

Treatments

Medications

Rosuvastatin Calcium Oral 5 MG 1 Tab(s) PO at bedtime
Phenylephrine HCl Nasal 0.5 % directed ml 2 sprays into each nostril every hrs as needed
Multi-vitamin/Minerals Oral 1 Tab(s) PO QD
Melatonin Oral 5 MG 1 Tab(s) PO at bedtime as needed
Gabapentin Oral 300 MG 1 Cap(s) PO BID
Erythromycin Ophthalmic 5 MG/GM directed Apply to both eyes every 6 hrs
Cyanocobalamin Sublingual 1000 MCG 1 Tab(s) PO QD
Citalopram Hydrobromide Oral 10 MG 2 Tab(s) PO QD
Cholecalciferol Oral 50 MCG (2000 UT) 1 Cap(s) PO QD
Calcium Carbonate Antacid Oral 500 MG 1 Tab(s) PO QD
Budesonide-Formoterol Fumarate Inhalation 160-4.5 MCG/ACT 2 puffs Inhale 2 puffs BID
Benzonatate Oral 100 MG 1 Cap(s) PO TID
Aspirin Oral 81 MG 1 Tab(s) PO QD
Ascorbic Acid Oral 250 MG 3 Tab(s) PO BID
amlodipine Besylate Oral 2.5 MG 1 Tab(s) PO QD
Acetaminophen Oral 500 MG 1 Tab(s) PO every 6 hrs PRN

Allergies

Substance

Penicillins

Reaction

Rash

Orders and Treatments

Advance Directives? Yes.

Intent: Medical Power of Attorney (Paula Pereira), Other: Full code

Copies on file with Agency? No.

Surrogate: Yes (Paula Pereira)

Patient was provided written and verbal information on Advance Directives? Yes.

Assessment of patient with Pneumonia, unspecified organism, Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny, Chronic kidney disease, stage 3a, Polyosteoarthritis, unspecified, Other hyperlipidemia, unspecified cataract, other specified postprocedural states.

Homebound Status: Homebound: Yes

Patient is confined because of illness, needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

Patient has a normal inability to leave home.

Leaving home requires a considerable and taxing effort for the patient.

Specify: Patient has difficulty exiting the home and due to fall risk, unsteady gait and poor

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(Continued) Orders and Treatments

endurance that requires the assistance of another person to leave the home.

Notify physician of: Temperature greater than (>) 100.7 or less than (<) 96.
Pulse greater than (>) 120 or less than (<) 50.
Respirations greater than (>) 25 or less than (<) 10.
Systolic BP greater than (>) 170 or less than (<) 50.
Diastolic BP greater than (>) 100 or less than (<) .
O2 Sat less than (<) 88%.

Frequencies

Physical Therapy:

4/27/2025 (Sunday) - 5/3/2025 (Saturday) 1 visit per week for 1 week
* Narrative Statement/Order Details: Skilled PT Treatment
5/4/2025 (Sunday) - 6/7/2025 (Saturday) 2 visits per week for 5 weeks
* Narrative Statement/Order Details: Skilled PT Treatment
6/8/2025 (Sunday) - 6/21/2025 (Saturday) 1 visit per week for 2 weeks
* Narrative Statement/Order Details: Skilled PT Treatment

Additional Orders:

This 86-y.o. female patient alert, forgetfulness at baseline, is admitted to Nightingale Home Health Services today via physician referral secondary to Pneumonia both lower lobes with subsequent dyspnea, weakness and unsteadiness of gait. PMHx includes Pneumonia both lower lobes, Vertigo, HLD, CKD 3A, HTN, cataract, generalized OA, other HLD, Shoulder surgery. Patient lives with a supportive daughter (PCA) and uses 4ww for ambulation; 5 to 6 stairs with rail to enter the house but uses the garage door without stairs to get out of the house. Upon PT assessment, the patient shows deficits on B LE strength, balance and endurance that affects overall transfer and ambulation. The patient needs to continue skilled PT services to help improve B LE strength, balance and endurance, therefore helping the patient reach the highest potential. Current status: Pt complains of no pain upon this visit; Supine < > Sit at CGA level; Sit <> stand and Transfers at CGA; Ambulatory with 4ww at CGA level x 20 ft on even surfaces with rests due to SOB, deficits of strength, endurance and balance; B LE strength of 3+/5 grossly; High fall risk (Tinetti of 17/28); Stair climbing at not tested this visit. Based on overall PT assessment, the patient needs to continue skilled PT services at this time to address deficits. Safety awareness emphasized during this visit to prevent future falls.

Patient is a full code. Systems: Skin is warm, dry and intact; urinating and moving bowels without difficulty; vital signs are stable; lungs clear to auscultation; has a good appetite and is taking food and fluids without difficulty.

The Nightingale handbook was reviewed with the patient/caregiver, discussed patient rights and responsibilities, definition of home-bound status, HIPPA, universal precautions, and washing techniques, the emergency care plan, signs and symptoms of infection, procedure for complaint resolution, and important phone numbers were pointed out. The patient was informed of all services available as well as the Nightingale phone line available 24 hours a day for non-emergency concerns. All consents were explained; completed and signed; all questions answered.

PT Interventions

Patient identified to be at High risk for falls. Physical Therapy to provide skilled assessment, identify and mitigate risk factors, provide instruction and reinforcement of teaching to prevent falls/injury to perform muscle re-education to restore previous function to help prevent future falls.

Patient identified to be at High risk for falls. Physical Therapy to provide skilled assessment, identify and mitigate risk factors, provide instruction and reinforcement of teaching to prevent falls/injury to perform muscle re-education and restore previous function to help prevent future falls.

Physical Therapy to provide education on proper implementation of B LE exercises to perform muscle

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(Continued) Orders and Treatments

re-education to restore previous function and help prevent future falls and muscle deconditioning. Physical Therapy to perform therapeutic exercises and provide patient with home exercise program to restore functional strength and mobility, provide patient with home exercise program to restore functional strength and mobility, skilled assessment, identify and mitigate risk factors, provide instruction and reinforcement of teaching to perform muscle re-education to restore previous function and to help prevent future falls and muscle deconditioning.

Physical Therapy to provide education on safe Sit <> stand and overall Transfers to perform muscle re-education to restore previous function and help prevent future falls.

Physical Therapy to provide education on safe ambulation and maneuverability to perform muscle re-education to restore previous function and improve gait stability and promote safety.

Patient identified to be at High risk for falls. Physical Therapy to provide skilled assessment, identify and mitigate risk factors, provide instruction and reinforcement of teaching in proper bed mobility to prevent falls/injury.

Goals and Outcomes

PT Goals

Patient will demonstrate no falls within this episode. (Goal Term: long, Target Date: 6/22/25)

Patient will improve balance as evidenced by the Tinetti POMA test score to greater than or equal to 22/28 (Moderate Fall Risk) to allow patient to have safe mobility, improve transfers, stair climbing and ambulation and promote safety. (Goal Term: long, Target Date: 6/22/25)

Patients strength of Bilateral hip and knee flexor and extensor muscle group; Bilateral ankle dorsiflexors and plantarflexor muscle groups to improve to ½ to 1 muscle grade or more grossly to allow patient to have safe mobility, improve transfers, stair climbing, ambulation and promote safety. (Goal Term: long, Target Date: 6/22/25)

Patient/Family/Caregiver will demonstrate ability to follow home exercise program (HEP) at SBA or higher within this episode. (Goal Term: long, Target Date: 6/22/25)

Patient will improve ability to safely Transfer to Modified Independent level with or without ambulatory assistive device to allow patient to have safe mobility and avoid falls. (Goal Term: long, Target Date: 6/22/25)

Patient will improve gait capacity as evidenced by the ability to ambulate with ambulatory assistive device at Modified Independent level or better for 50 ft or more on even surfaces to allow patient to have safe mobility and avoid falls within this episode. (Goal Term: long, Target Date: 6/22/25)

Patient will perform Supine < > Sit at Mod A or better within this episode. (Goal Term: long, Target Date: 6/22/25)

Rehab potential: Good to achieve stated goals with skilled intervention and patient's compliance with the plan of care.

Discharge plans: Discharge when medical condition is stable and patient is no longer in need of skilled services.

Discharge to care of physician.

Discharge to caregiver.

Discharge when goals met/maximum potential is reached.

Nurse Signature and Date of Verbal SOC Where Applicable
Digitally Signed by: LLOYDS BAYNOSA , PT

Date
04/24/2025

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.

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.

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Date: 7/1/2025

Primary Physician WILL, CHRISTINE MD	Address 535 Faunce Corner Rd NORTH DARTMOUTH, MA 02747	Phone Number (508) 996-3991
NPI 1760458632		Fax Number (508) 961-2535
Attending Physician's Signature and Date Signed --		Date --

Clinician: Clinician, Agency

Signature:

Date: 7/1/2025