Patient Information

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.
--	08/22/2019	From: 05/22/2025 To: 07/20/2025	101000978

Patient's Name and Address	Gender	Date of Birth	Phone Number
Debarros, Maria 120 Crossroads Dr North Dartmouth, MA 02747	Female	11/29/1941	(508) 961-9778
	Email --		Primary Language English

Patient Risk Profile
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Clinical Data

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

Primary Diagnosis

Code	Description	Date
F32.3	Major depressv disord, single epsd, severe w psych features (O)	01/31/2023

Secondary/Other Diagnosis

Code	Description	Date
E11.9	Type 2 diabetes mellitus without complications (E)	01/31/2023
F06.4	Anxiety disorder due to known physiological condition (E)	01/31/2023
I10.	Essential (primary) hypertension (E)	01/31/2023
F20.9	Schizophrenia, unspecified (E)	01/31/2023
E66.9	Obesity, unspecified (E)	01/31/2023
H54.7	Unspecified visual loss (E)	01/31/2023
E78.5	Hyperlipidemia, unspecified (E)	01/31/2023
Z68.32	Body mass index [BMI] 320-329, adult (E)	01/31/2023
Z79.84	Long term (current) use of oral hypoglycemic drugs (E)	01/31/2023
Z79.02	Long term (current) use of antithrombotics/antiplatelets (E)	01/31/2023
Z85.3	Personal history of malignant neoplasm of breast (E)	01/31/2023
Z90.11	Acquired absence of right breast and nipple (E)	01/31/2023
Z87.01	Personal history of pneumonia (recurrent) (E)	01/31/2023

Mental Status

Orientation:
Person: Oriented. Time : Oriented.
Place : Oriented. Situation: --

Memory: Forgetful.

Neurological: No problems.

Mood: Appropriate (WNL).

Behavioral: Impaired judgement, Poor coping skills, Poor decision making.

Psychosocial: Lives alone. HX of depression. Denies concerns at this time. Follows with Brighter side wellness

Additional Information: --

Clinician: Clinician, Agency

Signature:

Date: 7/9/2025

DME & Supplies
Grab Bars. Exam Gloves. Tub/Shower Bench. , Locked medication box, medication organizer.

Prognosis
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Safety Measures
Keep Pathway Clear. Instructed on disaster/emergency plan. Instructed on DME & electrical safety. Instructed on mobility safety. Emergency Plan Developed. Instructed on safe utilities management. Anticoagulant Precautions. Safety in ADLs. Instructed on safety measures. Sharps Safety. Fall Precautions. Standard Precautions/Infection Control. Instructed on sharps container. , Triage/Risk Code: 2, Disaster Code: 2

Nutritional Requirements
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Functional Limitations
Bowel/Bladder Incontinence, Endurance

Other
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Activities Permitted	Other
Up as tolerated	--

Treatments

Medications
Senna Oral 8.6 MG 2 Tab(s) Take two tabs every day in AM
Trintellix Oral 20 MG 1 Tab(s) Take one 20 mg tablet at HS
Acetaminophen-Codeine Oral 300-30 MG 1/2 Tab(s) Take half tab by mouth three times a day as needed
RisperDAL Oral 1 MG 1.5 Tab(s) Take 1 and a half tab to equal 1.5 mg at HS
Flonase Nasal 50 MCG/ACT 1 ml Adminsiter one puff up each nostril one time a day
Furosemide Oral 20 MG 1 Tab(s) Take one tablet daily
Clopidogrel Bisulfate Oral 75 MG 1 Tab(s) Take one tablet at dinner
metFORMIN HCl Oral 500 MG 2 Tab(s) 500 MG ORAL TABLET 2 tablet BID
Lisinopril Oral 20 MG 1 Tab(s) 20 MG ORAL TABLET 1 tab 1 tab daily
Remeron SolTab Oral 45 MG 1 Tab(s) Take one tab at HS
Isosorbide Mononitrate ER Oral 60 MG 1 Tab(s) daily
Magnesium Oxide Oral 400 MG 1 Tab(s) BID
Metoprolol Tartrate Oral 50 MG 1 Tab(s) BID
Pantoprazole Sodium Oral 40 MG 1 Tab(s) daily
Xanax Oral 1 MG 1 Tab(s) 1 MG ORAL TABLET 1 tab daily at HS
Rosuvastatin Calcium Oral 10 MG 1 Tab(s) 10 MG ORAL TABLET 1 tablet every evening
Felodipine ER Oral 10 MG 1 Tab(s) 10 MG ORAL TABLET, EXTENDED RELEASE 1 tablet once daily
Vitamin D3 Oral 25 MCG (1000 UT) 1 Tab(s) 1000 INTL UNITS ORAL CAPSULE 1 tablet once daily
metFORMIN HCl Oral 500 MG 2 Tab(s) 500 MG ORAL TABLET 2 tablets every evening
B12 Sublingual 5000 MCG 2 Tab(s) 1000mcg 1 tab daily by mouth
Aspirin Oral 81 MG 1 Tab(s) 81 MG ORAL TABLET, CHEWABLE 1 tab 2 x day
Tylenol Oral 325 MG 2 Tab(s) 650 MG ORAL TABLET, 1 tablet every 8 hours By mouth
Vitamin C Oral 500 MG 1 Cap(s) 500mg 1x daily By mouth

Allergies

Substance	Reaction
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Clinician: Clinician, Agency

Signature:

Date: 7/9/2025

Orders and Treatments
Advance Directives? No.
Intent:
Copies on file with Agency?
Surrogate: No
Patient was provided written and verbal information on Advance Directives? No.

Assessment of patient with Major depressv disord, single epsd, severe w psych features,Type 2 diabetes mellitus without complications,Anxiety disorder due to known physiological condition Essential (primary) hypertension,Schizophrenia, unspecified,Obesity, unspecified,Unspecified visual loss,Hyperlipidemia, unspecified,Body mass index [BMI] 320-329, adult,Long term (current) use of oral hypoglycemic drugs.
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.

Frequencies

Skilled Nursing:

5/22/2025 (Thursday) - 7/12/2025 (Saturday) 3 visits per week for 8 weeks
* Narrative Statement/Order Details: Three times a week

Additional Orders:
RECERT completed today.

Patient seen for recertification of nursing services. Presents pleasant and cooperative throughout assessment visit. She is alert and oriented x3, though forgetful at times (baseline). PMH includes: non-insulin-dependent diabetes, right-sided breast cancer with mastectomy, HTN, major depressive disorder with suicidal ideation and attempts, hallucinations, and paranoia. Patient has unstable psychiatric status due to multiple suicide attempts and multiple co-morbidities.

Patient currently seen by SN 3x/week for assessment and med management. This morning's CBG reported as 113; patient continues to log readings. Vitals remain at baseline. LSCA bilaterally, no edema noted. Patient denies GI/GU issues. Chronic sciatic pain continues, managed with pain management. No SI/HI reported. Patient maintains contact with counselor/CM through SWH and follows up with Brighter Side Wellness. No questions or concerns expressed. POC reviewed; patient agrees to ongoing SN services for med management, disease management and education, and medication education. Medications stored in lockbox for safety and to prevent mismanagement. SN preps meds in clearly marked containers until next visit to assess compliance. SN continues communication with counseling services and therapist for continuity of care. Patient has no willing or able caregiver, lives alone in elderly housing complex. Unable to safely manage medications independently due to illiteracy and primary Portuguese language, preventing her from adjusting medications if changes occur.

SN Interventions
SN to assess blood sugar via finger stick every visit prior to insulin administration
SN to establish reminders to alert patient to take medications at correct times
Sn to assess each visit SN to manage med refills and prepping Cont with lockbox with SN management
Fill med planner for per MD orders, request refills and prep for patient to self admin
SN to educate on proper coping mechanisms
Pt with unstable psych history - SN to assess each visit for any psych symptoms such as HI/SI/Paranoia

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Signature:

Date: 7/9/2025

(Continued) Orders and Treatments
SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit

Goals and Outcomes

SN Goals
Patient will remain free of s/s of hypo/hypergycemia throughout cert period (Goal Term: long, Target Date: 7/20/25)
Patient will be compliant with medication regimen throughout cert period (Goal Term: long, Target Date: 7/20/25)
Patient will demonstrate appropriate coping mechanisms throughout cert period. Neuro / Psych will remain stable throughout cert. (Goal Term: long, Target Date: 7/20/25)
Patient will achieve pain level less than 4 within within the episode of care (Goal Term: short, Target Date: 7/20/25)
Patient will verbalize an understanding of diabetic foot care (Goal Term: long, Target Date: 7/20/25)

Rehab potential: Fair 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.

Nurse Signature and Date of Verbal SOC Where Applicable	**Date**
Digitally Signed by: Julie Giordano , RN	05/19/2025

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.

Primary Physician	**Address**	**Phone Number**
JAUREGUI, HUGO MD	531 Faunce Corner Rd NORTH DARTMOUTH, MA 02747	(508) 996-3991
NPI		**Fax Number**
1124084611		(508) 961-2535

Attending Physician's Signature and Date Signed	**Date**
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Clinician: Clinician, Agency

Signature:

Date: 7/9/2025