Patient Information

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.
--	11/19/2024	From: 05/18/2025 To: 07/16/2025	MA230222024501

Patient's Name and Address	Gender	Date of Birth	Phone Number
Bergeron, Pauline 114 Riverside Ave, Apt 124 New Bedford, MA 02746	Female	02/22/1945	(508) 995-5866
	Email --		Primary Language English

Patient Risk Profile
Risk Factors: 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.

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
E11.65	Type 2 diabetes mellitus with hyperglycemia	11/19/2024

Secondary/Other Diagnosis

Code	Description	Date
I10.	Essential (primary) hypertension ( )	11/19/2024
F20.9	Schizophrenia, unspecified ( )	11/19/2024
R13.10	Dysphagia, unspecified ( )	11/19/2024
E78.5	Hyperlipidemia, unspecified ( )	11/19/2024
K21.9	Gastro-esophageal reflux disease without esophagitis ( )	11/19/2024
Z79.4	Long term (current) use of insulin ( )	11/19/2024
Z90.89	Acquired absence of other organs ( )	11/19/2024

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

Memory: Forgetful.

Neurological: No problems.

Mood: Appropriate (WNL).

Behavioral: Appropriate (WNL).

Psychosocial: baseline forgetfulness, confusion.

Additional Information: --

DME & Supplies
Cane. Diabetic Supplies. Grab Bars. Exam Gloves. Alcohol Pads.

Prognosis
Fair

Clinician: Clinician, Agency

Signature:

Date: 7/10/2025

Safety Measures
Emergency Plan Developed. Safety in ADLs. Sharps Safety. Fall Precautions. Use of Assistive Devices. Standard Precautions/Infection Control. Instructed on sharps container. , Triage/Risk Code: 002, Disaster Code: 002

Nutritional Requirements
Other: DM diet, puree.
No Concentrated Sweets.

Functional Limitations
Endurance

Other
--

Activities Permitted
Up as tolerated, Walker

Other
--

Treatments

Medications
NovoLOG Mix 70/30 FlexPen Subcutaneous (70-30) 100 UNIT/ML 0 Sliding scale before breakfast & before dinner:
Breakfast-
CBG less than 90 give 22 units
CBG 90-149 give 22 units
CBG 150-199 give 22 units
CBG 200-249 give 24 units
CBG 250-299 give 24 units
CBG 300-349 give 26 units
CBG >350 give 26 units
Dinner-
CBG 90-149 give 18 units
CBG 150-199 give 18 units
CBG 200-249 give 20 units
CBG 250-299 give 20 units
CBG 300-349 give 22 units
CBG >350 give 22 units (C)
Ketoconazole External 2 % 1 Apply to affected areas by topical route twice daily as needed
prednisoLONE Acetate Ophthalmic 1 % 1 ml instill one drop to both eyes twice daily
Refresh Tears Ophthalmic 0.5 % 1 ml Instill one drop to each eye twice daily.
Thioridazine HCl Oral 50 MG 1 Tab(s) PO AM and afternoon daily.
Thioridazine HCl Oral 25 MG 1 Tab(s) PO HS daily
Tab-A-Vite/Iron Oral 1 Tab(s) PO AM daily
Pantoprazole Sodium Oral 40 MG 1 Tab(s) PO AM daily
Nystatin External 100000 UNIT/GM 1 Topically applied 2x daily PRN affected areas.
Lipitor Oral 20 MG 1 Tab(s) PO HS daily
Ferrous Sulfate Oral 325 (65 Fe) MG 1 Tab(s) PO AM daily
Colace Oral 100 MG 1 Cap(s) PO 2x daily PRN constipation.
Cholecalciferol Oral 50 MCG (2000 UT) 1 Cap(s) PO AM daily
Benztropine Mesylate Oral 0.5 MG 1 Tab(s) PO HS daily
amLODIPine Besylate Oral 5 MG 1 Tab(s) PO AM daily
Tylenol Extra Strength Oral 500 MG 2 Tab(s) PO 3x daily
Loratadine Oral 10 MG 0.5 Tab(s) PO 5mg PRN allergies.
Flonase Nasal 50 MCG/ACT 1 ml via each nostril 1 spray as needed rhinitis.

Clinician: Clinician, Agency

Signature:

Date: 7/10/2025

Allergies

Substance	Reaction
NKA (Food / Drug / Latex / Environmental)	--

Orders and Treatments

Advance Directives? Yes.
Intent: Other: Full Code
Copies on file with Agency?
Surrogate:
Patient was provided written and verbal information on Advance Directives?

Assessment of patient with Type 2 diabetes mellitus with hyperglycemia,Essential (primary) hypertension,Schizophrenia, unspecified,Dysphagia, unspecified,Hyperlipidemia, unspecified Gastro-esophageal reflux disease without esophagitis,Long term (current) use of insulin,Acquired absence of other organs.
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:

5/18/2025 (Sunday) - 7/16/2025 (Wednesday) 2 visits per day for 60 days
* Narrative Statement/Order Details: Eval and treat, education

PRN Orders:
Effective Date: 05/18/2025
Discipline: Skilled Nursing
Number of PRN Visits: 3
Narrative Statement/Order Details: eval and treat Education

Additional Orders:
Recert with Oasis
PCP Dr Mackler

PMH type 2 DM, hypercalcemia, HTN, Hyperlipidemia, GERD

Patient is a 79 y/o woman initially referred to NHHC following hospitalization from 11/11/24 with d/c home 11/19/24. Patient was transferred to St Lukes via EMS from urgent care where she was found to have severely high CBG which was unreadable when tested at urgent care. Patient symptoms included frequent urination which led to urgent care visit. Patient was dx with new onset type 2 DM. Patient was prescribed insulin at the time. Patient d/t cognitive deficit is not able to be educated to safe insulin management. PT lives in an assisted living where staff is able to adminster PO medications in certain circumstances however under no circumstances are they able to administer insulin. In this situation patient has no one else available for assistance, requires SN need for safe insulin management.
Patient is currently prescribed Novolog 70/30 35 units in AM and 25 units in PM.
SN reviewed basic diet changes to continue including eliminating sugar containing sodas, candy and ice cream from diet completely.
Patient vitals are stable. CBG 160 at visit and no s/s altered glycemia. Patient meal are prepared by assisted living staff
Pt presented with baseline confusion and forgetfulness, patient did not always answers questions appropriately or correctly.

Clinician: Clinician, Agency

Signature:

Date: 7/10/2025

(Continued) Orders and Treatments

Patient denied pain or discomfort at any time. Denies headache, dizziness or light headed. Denies chest pain or pressure at any time. Lung sounds clear not cough or congestion. Abdomen soft and nontender. Positive bowel sounds and regular BM. Patient denies any s/s UTI and urinary frequency has improved with better controlled CBGs. Patient has rolling walker and cane which she uses for stability and safely with ambulation. Skin is CDI.
SN 2x daily for insulin management and administration. SN to provide head to toe assessment with documentation on problem areas. SN to communicate with staff and MD as necessary
Hippa, patient rights/ responsibilities reviewed.
d/c plan initiated..

SN Interventions
SN to secure insulin in lock box. Lock box code 98
SN to instruct the patient the following symptoms could be signs of a heart attack: chest discomfort, discomfort in one or both arms, back, neck, jaw, stomach, shortness of breath, cold sweat, nausea, or dizziness. Instruct patient on signs and symptoms that necessitate calling 911
SN to instruct the Patient on measures to recognize cardiac dysfunction and relieve complications
SN to assess Cardiac status/BP, Resp status/O2 sat PRN, LS, provide pt education on disease process and management. provide education on cardiac/resp status, s/s to report to SN/MD/EMS
SN to prep and admin gtts to OU with each SNV a/o by MD.
SN to assess for patient adherence to appropriate activity levels
Assess for recent falls. Instruct/reinforce on all aspects of fall prevention strategies including maintaining clear pathways, proper lighting and non-slip footwear. Teach fall emergency plan. May refer to therapies for evaluation if need is identified.
SN to assess blood sugar via finger stick every visit prior to insulin administration
SN to instruct patient on all aspects of diabetes and management as well as management of hypo/hyperglycemia.
Sliding scale before breakfast & before dinner:
Breakfast-
CBG less than 90 give 22 units
CBG 90-149 give 22 units
CBG 150-199 give 22 units
CBG 200-249 give 24 units
CBG 250-299 give 24 units
CBG 300-349 give 26 units
CBG >350 give 26 units
Dinner-
CBG 90-149 give 18 units
CBG 150-199 give 18 units
CBG 200-249 give 20 units
CBG 250-299 give 20 units
CBG 300-349 give 22 units
CBG >350 give 22 units
SN to develop individualized emergency plan with patient
Assess neurobehavioral status each visit. Monitor cognitive changes, behavior shifts, and daily functioning. Educate patient on disease management, stressing routines and safety. Teach anxiety/depression management: breathing exercises, coping strategies. Guide on reorientation: visual cues, clear communication to minimize confusion.
Ketoconazole 2% cream- Apply to affected areas by topical route twice daily as needed

Goals and Outcomes

SN Goals
patient Will verbalize understanding of medication regimen including use, dose, route & time
(Goal Term: long, Target Date: 7/16/25)

Clinician: Clinician, Agency

Signature:

Date: 7/10/2025

(Continued) Goals and Outcomes

Pt blood pressure to remain WNL. (Goal Term: long, Target Date: 7/16/25)
SN to Admin ophthalmic solutions as order by MD. (Goal Term: long, Target Date: 7/16/25)
The patient will be free from injury during the certification period (Goal Term: long, Target Date: 7/16/25)
Patients blood sugar levels will be within normal limits as established by MD. (Goal Term: long, Target Date: 7/16/25)
Patient will have no hospitalizations this episode. (Goal Term: long, Target Date: 7/16/25)
Patient skin integrity will remain intact during this episode (Goal Term: long, Target Date: 7/16/25)

Rehab potential: Fair to achieve stated goals with skilled intervention and patient's compliance with the plan of care.
Discharge plans: Discharge when goals met.

Nurse Signature and Date of Verbal SOC Where Applicable	**Date**
Digitally Signed by: Sara Lewis , RN	05/14/2025

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**
MACKLER, STEPHEN MD	535 FAUNCE CORNER RD NORTH DARTMOUTH, MA 02747	(508) 996-3991
NPI		**Fax Number**
1669442745		(508) 961-2535

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

Signature:

Date: 7/10/2025