Patient Information

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.
--	06/02/2017	From: 06/20/2025 To: 08/18/2025	100990085

Patient's Name and Address	Gender	Date of Birth	Phone Number
Dacosta, Marialucil 10 Puritan Way New Bedford, MA 02745	Female	01/13/1934	(508) 991-1622
	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.

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
I10.	Essential (primary) hypertension	12/29/2022

Secondary/Other Diagnosis

Code	Description	Date
L03.115	Cellulitis of right lower limb ( )	12/29/2022
R60.0	Localized edema ( )	12/29/2022
F03.90	Unsp dementia, unsp severity, without beh/psych/mood/anx ( )	12/29/2022
M81.0	Age-related osteoporosis w/o current pathological fracture ( )	12/29/2022
Z79.82	Long term (current) use of aspirin ( )	12/29/2022

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

Memory: Forgetful.

Neurological: No problems.

Mood: Depressed, Anxious.

Behavioral: Poor coping skills.

Psychosocial: --

Additional Information: --

DME & Supplies
Nebulizer. Oxygen. Exam Gloves. Walker. , 2.5l

Prognosis
Fair

Clinician: Clinician, Agency

Signature:

Date: 7/9/2025

Safety Measures
Keep Pathway Clear. Emergency Plan Developed. Anticoagulant Precautions. Safety in ADLs. Fall Precautions. Standard Precautions/Infection Control. , Triage/Risk Code: 2, Disaster Code: 2

Nutritional Requirements
No Added Salt. Regular. Heart Healthy.

Functional Limitations
Bowel/Bladder Incontinence, Endurance, Dyspnea

Other
--

Activities Permitted	**Other**
Cane	--

Treatments

Medications
Diclofenac Sodium External 1 % 100gm apply 2 grams topically to affected are four times daily
Pentoxifylline ER Oral 400 MG 60 Tab(s) 1 tab by mouth twice daily
Nystatin External 100000 UNIT/GM 30gm apply topically to abdominal folds twice daily as needed
Furosemide Oral 20 MG 1 Tab(s) daily PRN
Vitamin B-12 Oral 500 MCG 1 Tab(s) 1 tab qd po
ALPRAZolam Oral 0.25 MG 60 Tab(s) 1 tab by mouth twice daily as needed
Omeprazole Oral 20 MG 1 Cap(s) twice daily
Tylenol Oral 325 MG 1-2 Tab(s) every 4hrs PRN
Cholecalciferol Oral 10 MCG (400 UNIT) 1 Cap(s) daily
Metoprolol Tartrate Oral 50 MG 1 Tab(s) 50 mg twice daily By mouth
Calcium-Vitamin D Oral 500-125 MG-UNIT 1 Tab(s) 500+D 1 tab twice daily By mouth
Aspirin Oral 81 MG 1 Tab(s) 81 MG ORAL TABLET 1 tab daily By mouth

Allergies

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

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

Assessment of patient with Essential (primary) hypertension,Cellulitis of right lower limb,Localized edema,Unsp dementia, unsp severity, without beh/psych/mood/anx,Age-related osteoporosis w/o current pathological fracture,Long term (current) use of aspirin.
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

Clinician: Clinician, Agency

Signature:

Date: 7/9/2025

(Continued) Orders and Treatments

Skilled Nursing:

6/20/2025 (Friday) - 8/18/2025 (Monday) 1 visit per day for 60 days
* Narrative Statement/Order Details: sn

PRN Orders:
Effective Date: 06/20/2025
Discipline: Skilled Nursing
Number of PRN Visits: 3
Narrative Statement/Order Details: prn

Additional Orders:
PCP: Daniel Martin, MD.
INSUR: SWH

Patient is seen today for Recertification of ongoing daily skilled nursing visits.
Nursing intervention required daily for med management and administration due to h/o mismanagement and noncompliance. .
Patient is a 91 year old female with dementia who lives alone in single family 2 level home.
patient is alert & Oriented x 2-3, confused and forgetful at baseline.
Portuguese speaking woman, her children take turns checking on patient in the evening after work.
daughter assists patient with showers and appointments.
Patients mood is pleasant and cooperative throughout. o.
Patient has PMhx of HTN, RLE cellulitis, GERD, and Dementia.
Patient denies any H/A or dizziness.
+ BM this morning. Abdomen soft non tender, bowel sounds present in all 4 quadrants. +BS x4.
No blood in stool or diarrhea reported at this time.
Patient is not incontinent of bowel or bladder. Patient reports urine is yellow, clear and odorless.
Skin is unremarkable. Skin remains, clean dry and intact.
trace edema at baseline .
Patient continues on PRN lasix.
SN to assess BLE edema every morning.
+CSM, good circulation and turgor present. Patient denies any pain.
Patient maintaining eye contact. Answering questions slowly.
Patient is currently being seen daily for SN to assess mood, mental status, vital signs, safety, coping skills, disease process teaching, medication assessment, education and monitor compliance.
Patient denies any SI/HI, AH/VH, racing thoughts or paranoia at this time. Medications reviewed with patient during visit, patient presents with increased anxiety, confusion and becomes easily overwhelmed when receiving education regarding medications. Without SN intervention patient becomes at risk for decompensation/ hospitalization secondary to disease process as evidenced by poor insight and poor judgment. Patients thought process is impaired, creating a barrier for the patient to achieve optimal goal function. Patient requires a lock box to prevent any accidental or intentional misuse of medication. Patient has a history of misusing medication. Patient has not had any hospitalizations in the last 60 days. Patient had one medication change.
Skilled Nursing Goals include: Patient will remain free from s/sx of mental decompensation and hospitalization. Patient will remain compliant with medication regimen. Patients mood will remain at baseline. Patient will utilize positive coping skills. Patient to learn medication identifiers, mode of action, dose, timing and side effects to report for all medications. Long term goal of patient to be independent with medication management and to remain safe in the community. Patients barriers to achieving these goals are poor insight into disease process, history of medication non compliance, impaired solving problem and inability to independently manage complex medication regimen.

The discharged plans that were discussed and established with patient include the following: Patient to be discharged when the patient is able to understand the medication regime and care related to disease process, diagnosis and all goals have been met. Upon discharged, patient is to remain safe in the community and residence.

Clinician: Clinician, Agency

Signature:

Date: 7/9/2025

(Continued) Orders and Treatments

SN Interventions
sn to admin daily PO am meds, prep PM meds in clearly labeled cup for patient to self admin. sn to assess compliance with previously prepped meds SN to perform medication review each skilled nursing visit and reconcile medications as indicated. SN to instruct on all new and changed medications and reinforce teaching related to use of medications as part of disease process or demonstration of knowledge deficit.
869 medication management doctors order daily daily med management daily
SN to obtain O2 sats at every visit.
SN to assess Lung sounds at every visit.
SN to instruct patient/caregiver regarding strategies to mitigate pain including medication administration, recording and reporting pain; non-pharmacological treatments including positioning, massage, visualization, distraction and cold or warm compresses.
sn to assess and educate pt on cellulitis s/s to report
SN to minimize/eliminate risk for hospitalization due to problems associated with poor health literacy.
SN to provide skilled assessment, teaching/training and reinforcement of teaching to properly assess, manage and mitigate pain.
SN to assess edema to bilat. lower extremities
SN to apply Tubigrip to bilat. lower extremities as needed
SN to instruct patient/caregiver regarding self-management of hypertensive status.
SN to assess cardiovascular status, identify any signs and symptoms of impaired cardiovascular function. SN to instruct patient on disease process, including who to contact if signs and symptoms persist or worsen as well as dietary measures, medication management, activities permitted. May obtain O2 saturation as needed for shortness of breath or s/s of complications.

Goals and Outcomes

SN Goals
Patient will demonstrate compliance with medication regimen as evidenced by correct administration, reporting side effects or adverse reactions by end of care (Goal Term: long, Target Date: 8/18/25)
lockbox 869 administration of medication every day in AM SN to prep & leave PM po meds (Goal Term: long, Target Date: 8/18/25)
Pt will verbalize an understanding of factors that contribute to SOB by the end of this episode of care (Goal Term: long, Target Date: 8/18/25)
Patient will demonstrate ability to manage pain medication regimen by end of care (Goal Term: long, Target Date: 8/18/25)
Patient will have no acute care hospitalizations, ER visits nor readmissions during this episode of care. (Goal Term: long, Target Date: 8/18/25)
Patient will have promotion of healing and restoration of skin integrity without complications by end of cert (Goal Term: long, Target Date: 8/18/25)
Patient will be able to verbalize signs and symptoms of cardiac complications, when to call physician, nurse or 911 by end of care patient will elevate lower extremity to reduce swelling (Goal Term: long, Target Date: 8/18/25)

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: TONIM DEMELLO , RN	06/18/2025

Clinician: Clinician, Agency

Signature:

Date: 7/9/2025

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 Martin, Daniel MD	**Address** 535 Faunce Corner Rd DARTMOUTH, MA 02714	**Phone Number** (508) 996-3991
NPI 1720058803		**Fax Number** (508) 213-3429

Attending Physician's Signature and Date Signed --	**Date** --

Clinician: Clinician, Agency

Signature:

Date: 7/9/2025