Patient Information

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.
--	02/09/2025	From: 06/09/2025 To: 08/07/2025	MA201027114506

Patient's Name and Address	Gender	Date of Birth	Phone Number
Azevedo, Isabel 90 Fern St New Bedford, MA 02744	Female	11/19/1945	(508) 825-4022
	Email --		Primary Language English

Patient Risk Profile
Risk Factors: Currently taking 5 or more medications.

Clinical Data

Clinical Manager	Branch Name and Address	Phone Number
Marshman, Dannielle	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	02/09/2025

Secondary/Other Diagnosis

Code	Description	Date
K21.9	Gastro-esophageal reflux disease without esophagitis ( )	02/09/2025
G30.9	Alzheimer's disease, unspecified ( )	02/09/2025
E78.5	Hyperlipidemia, unspecified ( )	02/09/2025
F32.A	Depression, unspecified ( )	02/09/2025
E11.65	Type 2 diabetes mellitus with hyperglycemia ( )	02/09/2025
Z79.4	Long term (current) use of insulin ( )	02/09/2025

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

Memory: Forgetful, Misplaces objects.

Neurological: Tremors.

Mood: Depressed, Anxious.

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

Psychosocial: ALzheimers and impaired cognition requires 24 hour supervision

Additional Information: --

DME & Supplies
Cane. Diabetic Supplies. Grab Bars. Tub/Shower Bench.

Prognosis
Fair

Clinician: Clinician, Agency

Signature:

Date: 7/7/2025

Safety Measures
Keep Pathway Clear. Instructed on disaster/emergency plan. Slow Position Change. Instructed on mobility safety. Emergency Plan Developed. Anticoagulant Precautions. Safety in ADLs. Instructed on safety measures. Sharps Safety. Fall Precautions. Use of Assistive Devices. Standard Precautions/Infection Control. Instructed on sharps container. , Triage/Risk Code: 2/2, Disaster Code: 3

Nutritional Requirements
No Added Salt. Regular. No Concentrated Sweets. Heart Healthy. Low Cholesterol.

Functional Limitations
Bowel/Bladder Incontinence, Endurance, Ambulation, Hearing

Other
--

Activities Permitted	Other
Up as tolerated, Cane	--

Treatments

Medications
Semglee Subcutaneous 100 UNIT/ML 12u @HS
hydroCHLOROthiazide Oral 12.5 MG 1 Cap(s) 1Xday.
Escitalopram Oxalate Oral 10 MG 1 Tab(s) once daily for depression (recent change while at Southcoast Behavioral)
Semaglutide (1 MG/DOSE) Subcutaneous 4 MG/3ML 1mg once weekly SQ for diabetes (FRIDAYS)
Metoprolol Tartrate Oral 50 MG 1 Tab(s) twice daily for blood pressure
amLODIPine Besylate Oral 10 MG 1 Tab(s) once daily for blood pressure
Magnesium Oxide Oral 400 MG 1 Tab(s) one tab daily
Colace Oral 100 MG 1 Cap(s) daily at bedtime for constipation
Ibuprofen Oral 600 MG 1 Tab(s) 1 tab BID PRN
HumaLOG KwikPen Subcutaneous 100 UNIT/ML - sliding scale TID before meals as directed
traZODone HCl Oral 50 MG 1/2 Tab(s) (25mg) TID PRN
risperiDONE Oral 0.25 MG 1 Tab(s) BID
Vitamin B12 5,000mcg po qd
Aspirin Oral 81 MG 1 Tab(s) qd
Tylenol 8 Hour Oral 650 MG 1 Tab(s) q6hrs PRN
Rosuvastatin Calcium Oral 40 MG 1 Tab(s) 40 MG ORAL CAPSULE 1x dat every evening
Lisinopril Oral 40 MG 1 Tab(s) 40 MG ORAL TABLET 1 tab 1 x day
Pantoprazole Sodium Oral 40 MG 1 Tab(s) 40 MG ORAL DELAYED RELEASE TABLET 1 tablet take 1 tab daily in the morning

Allergies

Substance	Reaction
Atorvastatin	bladder infection
Jardiance	bladder infection
trulicity	hives

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

Assessment of patient with Essential (primary) hypertension,Gastro-esophageal reflux disease without

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Signature:

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(Continued) Orders and Treatments
esophagitis,Alzheimer's disease, unspecified,Hyperlipidemia, unspecified,Depression, unspecified
Type 2 diabetes mellitus with hyperglycemia,Long term (current) use of insulin.
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: Pt is homebound due to decreased balance/coordination, increased falls risk, decreased safety awareness, decreased strength/endurance and requires assist of one person and a cane to safely leave the home.

Frequencies

Skilled Nursing:

6/9/2025 (Monday) - 8/7/2025 (Thursday) 1 visit per week for 9 weeks
* Narrative Statement/Order Details: SN medication management

PRN Orders:
Effective Date: 06/09/2025
Discipline: Skilled Nursing
Number of PRN Visits: 3
Narrative Statement/Order Details: SN medication management

Additional Orders:
RECERT 6-5-25

Pt cont to be followed by:
PCP- Dr.Coury

Pt seen today for recert. Over the last 60 days pt has been seen weekly for medication management d/t hx med mismanagement r/t med confusion. Pt lives with husband in a home located in New Bedford. Home appears clean but cluttered.

Pt a&o x3 with baseline forgetfulness. Pt husband present throughout visit. Pt pleasant and compliant throughout visit. SN assessed med planner for compliance with no issues noted. SN re-educated pt on importance of medication compliance and possible complications r/t non-compliance, pt verbalized partial understanding but reinforcement is needed. SN also filled med planner until next SN visit a/o. Pt able to accurately state how to safely self admin meds from med planner. Pt husband reports admin insulin prior to SN arrival and able to accurately state how to safely prep and admin insulin. Pt husband assist with DM/insulin management. Fasting cbg this AM 255. SN educated pt on importance of maint proper diabetic foot care, pt verbalized partial understanding but reinforcement is needed. SN will cont to monitor for any change in condition.

No medical appointments, medication changes, falls or hospitalizations within recert period

Pt will cont with POC as described. Skilled nursing required weekly for medication management d/t hx med mismanagement r/t med confusion, including teaching use, effect and dosing, skilled observation and assessment of cardiovascular system with teaching to include cardiac disease process, s/sx's to report, importance of adhering to diet and management of weight/edema, skilled observation and assessment of musculoskeletal system with teaching to include proper use of assistive devices, measures to decrease fall risk, safety with ADL's, skilled observation and assessment of DM with teaching to include disease process, s/sx's to report, importance of adhering to proper DM diet and management of CBG's

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Signature:

Date: 7/7/2025

(Continued) Orders and Treatments

SN Interventions
SN to instruct the Patient on medication regimen dose, indications, side effects, and interactions
SN to instruct the Patient on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, sedative hypnotics, antiarrhythmics, antineoplastics, skeletal muscle relaxants
SN to instruct Patient on medication side effects to report to SN or physician
SN to establish reminders to alert patient to take medications at correct times
SN to assess if the Patient can verbalize an understanding of the indication for each medication
SN to fill med planner weekly - -
SN to develop individualized emergency plan with patient
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 [dropdownm] Patient to remove clutter from patient's path such as clothes, books, shoes, electrical cords, or other items that may cause patient to trip
SN to instruct the [dropdownm] on importance of adequate lighting in patient area
SN to assess for changes in neurological status every visit
SN to assess patient's communication skills every visit
SN to assess for contributing sensor deficits
SN to instruct Patient on appropriate nail care as follows: trim nails straight across and file rough edges with nail file
SN to instruct Patient to never to try to cut off corns, calluses, or any other lesions from lower extremities
SN to instruct Patient to inspect patient's feet daily and report any skin or nail problems to SN
SN to instruct Patient that patient should never walk barefoot
SN to assess for patient adherence to appropriate activity levels
SN to instruct patient to use prescribed assistive device when ambulating
SN to instruct patient to wear proper footwear when ambulating

Goals and Outcomes

SN Goals
Patient will be able to verbalize an understanding of the indications for each medication by the end of the recert period (Goal Term: long, Target Date: 8/7/25)
Patient will verbalize understanding of need to control behaviors (Goal Term: long, Target Date: 8/7/25)
Patient will verbalize understanding of individualized emergency plan by (Goal Term: long, Target Date: 8/7/25)
Patient will have no hospitalization within recert period (Goal Term: long, Target Date: 8/7/25)
will verbalize understanding of symptoms of cardiac complications and when to call 911 by: (Goal Term: long, Target Date: 8/7/25)
Patient will remove clutter from patient pathway such as clothes, electrical cords and other items that may cause patient to trip by end of episode (Goal Term: long, Target Date: 8/7/25)
Patient will verbalize understanding of proper diabetic foot care by end of episode (Goal Term: long, Target Date: 8/7/25)
The patient will be free from injury during the certification period (Goal Term: long, Target Date: 8/7/25)

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.
Discharge to care of physician.
Discharge to caregiver.
Discharge when caregiver willing and able to manage all aspects of patient's care.
Discharge when goals met.
Discharge when reliable caregiver available to assist with patient's medical needs.

Clinician: Clinician, Agency

Signature:

Date: 7/7/2025

Nurse Signature and Date of Verbal SOC Where Applicable	**Date**
Digitally Signed by: BELINDAM BLANCHARD , RN	06/05/2025

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**
COURY, PAMELA	531 Faunce Corner Rd NORTH DARTMOUTH, MA 02747	(508) 996-3991
NPI		**Fax Number**
1598703944		(508) 961-0949

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

Signature:

Date: 7/7/2025