Patient Information

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.
--	02/01/2022	From: 05/16/2025 To: 07/14/2025	MA200720115101

Patient's Name and Address	Gender	Date of Birth	Phone Number
Pontes, Eugenio 76 Earle St, APT 1 02746 New Bedford, MA 02746	Male	11/03/1951	(508) 992-0285
	Email --		Primary Language English

Patient Risk Profile
Risk Factors: Currently taking 5 or more medications. Other risk(s) not listed in 1-8.

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
E11.65	Type 2 diabetes mellitus with hyperglycemia	11/29/2022

Secondary/Other Diagnosis

Code	Description	Date
I11.0	Hypertensive heart disease with heart failure ( )	11/29/2022
M48.061	Spinal stenosis, lumbar region without neurogenic claud ( )	11/29/2022
M17.11	Unilateral primary osteoarthritis, right knee ( )	11/29/2022
H91.93	Unspecified hearing loss, bilateral ( )	11/29/2022
F41.9	Anxiety disorder, unspecified ( )	11/29/2022
K21.9	Gastro-esophageal reflux disease without esophagitis ( )	11/29/2022
Z79.4	Long term (current) use of insulin ( )	11/29/2022

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

Memory: Forgetful.

Neurological: --

Mood: Depressed, Anxious.

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

Psychosocial: --

Additional Information: --

DME & Supplies
Diabetic Supplies. Grab Bars. Exam Gloves. Tub/Shower Bench. Sharps Container. Alcohol Pads.

Prognosis
--

Clinician: Clinician, Agency

Signature:

Date: 7/9/2025

Safety Measures
Instructed on disaster/emergency plan. Instructed on mobility safety. 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 Concentrated Sweets. Heart Healthy.

Functional Limitations
Endurance, Hearing

Other
--

Activities Permitted
Up as tolerated, Cane

Other
--

Treatments

Medications
HumaLOG Subcutaneous 100 UNIT/ML 1 ml Humalog 16 units at Lunch (C)
Lantus Subcutaneous 100 UNIT/ML 1 ml Admin 10 units sq daily in AM. (C)
HumaLOG KwikPen Subcutaneous 100 UNIT/ML 1 Admin Humalog 20 units sq with breakfast along with correctional scale 71-150 - No additional , 151-200 add 1 units, 201-250 add 2 units, 251-300 add 3 units, 301-350 add 4 units, 351-400 add 5 units, greater than 400, add 6 units. If BS is less than 70 HOLD sched. Humalog. If BS 71-100, Admin 1/2 dose of 20 units sq. (C)
HumaLOG KwikPen Subcutaneous 100 UNIT/ML 1 Admin Humalog 20 units scheduled sq with Dinner along with correctional scale 71-150 - No additional , 151-200 add 1 units, 201-250 add 2 units, 251-300 add 3 units, 301-350 add 4 units, 351-400 add 5 units, greater than 400, add 6 units. If BS is 70 or less HOLD Scheduled Humalog. If Bs 71-100. Admin 1/2 dose of 10 units sq. (C)
Lantus SoloStar Subcutaneous 100 UNIT/ML 80units Admin 80 units sq every PM. (C)
Mounjaro Subcutaneous 15 MG/0.5ML 0.5ml inject 0.5ml subcutaneously once weekly on Tuesday.
Jardiance Oral 25 MG 1 Tab(s) daily
Ferrous Sulfate Oral 324 MG 1 Tab(s) Daily in pm
Magnesium Oxide Oral 400 MG 1 Tab(s) Daily at dinnertime
Metoprolol Succinate ER Oral 25 MG 1 Tab(s) daily at hs
Pantoprazole Sodium Oral 40 MG 1 Tab(s) daily
Meloxicam Oral 15 MG 1 Tab(s) one tab by mouth once daily in the evening
traZODone HCl Oral 100 MG 1 Tab(s) daily at hs
Vitamin B-12 Oral 250 MCG 1 Tab(s) daily
Nitroglycerin Sublingual 0.4 MG 1 Tab(s) every 5 minutes x3 PRN for chest pain call 911 if no relief after 3 doses
metFORMIN HCl Oral 1000 MG 1 Tab(s) BID
Aspirin Oral 81 MG 1 Tab(s) daily
Atorvastatin Calcium Oral 40 MG 1 Tab(s) daily at HS
Lisinopril-hydroCHLOROthiazide Oral 20-12.5 MG 1 Tab(s) daily

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.

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Signature:

Date: 7/9/2025

(Continued) Orders and Treatments

Assessment of patient with Type 2 diabetes mellitus with hyperglycemia,Hypertensive heart disease with heart failure,Spinal stenosis, lumbar region without neurogenic claud,Unilateral primary osteoarthritis, right knee,Unspecified hearing loss, bilateral,Anxiety disorder, unspecified Gastro-esophageal reflux disease without esophagitis,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 condition such that leaving his or her home is medically contraindicated.
Specify: poor endurance unsteady gait.
Leaving home requires a considerable and taxing effort for the patient.
Specify: benefit from supervision and assist to safely leave home.

Frequencies

Skilled Nursing:

5/16/2025 (Friday) - 7/14/2025 (Monday) 2 visits per day for 60 days
* Narrative Statement/Order Details: SN VFO

Physical Therapy:

5/18/2025 (Sunday) - 5/24/2025 (Saturday) 1 visit per week for 1 week
* Narrative Statement/Order Details: PT eval

Occupational Therapy:

5/18/2025 (Sunday) - 5/24/2025 (Saturday) 1 visit per week for 1 week
* Narrative Statement/Order Details: OT eval

Additional Orders:
Recert with Oasis

Portuguese speaking male who lives with wife in first floor apartment.
PMH significant for DM-II, HTN, CHRONIC DIASTOLIC CHF, LUMBAR SPINAL STENOSIS, OA OF RIGHT KNEE, OSA, BILATERAL HEARING LOSS, OBESITY, IRON DEFICIENCY ANEMIA, ANXIETY, MIXED HLD DUE TO DM-II, GERD, CHRONIC CONSTIPATION, PERSISTENT INSOMNIA, FORMER SMOKER.

This episode patient was found to be non compliant with medication regularly including insulin. This was brought to SN attention by family who were concerned patient would miss multiple days medication in row. SN reviewed with patient and family risks of noncompliance including possible hospitalization or death. Patient requested increase of SN VFO for closer monitoring and safe medication management. SN offered increase to BID assume responsibility of medication management and insulin administration. Patient has been compliant with all medications including insulin since increase. SN monitors PO medication compliance at visits also.

Patient is a Portuguese speaking male resides home with spouse, due to her own medical condition she is unable to assist in any meaningful way with medication management. Pt denies any pain. Patient denies any H/A or dizziness. Abdomen soft non tender, bowel sounds present in all 4 quadrants. 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. No open or red areas present at this time. No edema present at this time. +CSM, good circulation and turgor present. Patient maintaining eye contact, answering questions appropriately. Patient is dressed appropriately. Patient is to continue to be seen weekly for SN to assess mood, mental status, vital signs, safety, coping skills, disease

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Signature:

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(Continued) Orders and Treatments

process teaching, medication assessment, education and monitor compliance. Patient remains unable to manage medications safely and independently. Patient has not had hospitalizations in the last 60 days. Patient has had medication changes in the last 60 days, related to his diabetes. Patient requiring ongoing education regarding short acting insulin administration and frequency. Pt voices no other questions or concerns at this time.

Skilled Nursing Goals include: Patient will remain free from s/sx of medical and mental health 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.
PT/OT eval added due to recent reports from patient of weakness.
I Steven Schoorens RN received a verbal order to either start, or continue services from date 5/16/25 through 7/14/25 .

SN Interventions
SN to instruct pt on diabetic management including disease process, importance of adhering to diabetic diet, and s/sxs of hypo/hyperglycemia.
Sn to administer weekly Mounjaro injection, during SN visit.
Sn to administer Lantus 80 units at PM visit
SN to prep/administer Lantus 10 units sq daily in AM.
SN to prep/admin standing dose of Humalog 20 units sq with correctional SSI if warranted during AM and PM visit. If BS is 70 or less HOLD standing dose of Humalog. If Bs 71-100. Admin 1/2 standing dose Humalog of 10 units sq.
SN to prep/admin 16 units of Humalog sq for patient to self administer at lunchtime.
SN to instruct patient to change positions slowly
SN to monitor BP at every visit and contact MD with elevated bp readings.
Sn to prepare and administer medications to patient twice daily.
May prepare medications for patient to self administer in the event patient is unavailable for SNV, or due to inclement weather
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 develop individualized emergency plan with patient
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

Goals and Outcomes

SN Goals
Pt will be free of s/sxs of hypo/hyperglycemia during this episode of care.
(Goal Term: long, Target Date: 7/14/25)
Pt to be free of any falls during this episode of care. (Goal Term: long,
Target Date: 7/14/25)
Pt's blood pressure will remain wnl during this episode of care. (Goal Term:
long, Target Date: 7/14/25)
Pt will comply with med regimen as ordered by MD, remain free from complications related to medications by the end of this episode of care. (Goal Term: long, Target Date:
7/14/25)
will verbalize understanding of symptoms of cardiac complications and when to call 911 by:
(Goal Term: long, Target Date: 7/14/25)

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.

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Signature:

Date: 7/9/2025

(Continued) Goals and Outcomes

Nurse Signature and Date of Verbal SOC Where Applicable	**Date**
Digitally Signed by: STEVENG SCHOORENS , RN	05/13/2025

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