Patient Information

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.
4QV9YC4FC16	03/21/2025	From: 05/20/2025 To: 07/18/2025	MA250318034804

Patient's Name and Address	Gender	Date of Birth	Phone Number
Medeiros, Rita 3012 Fox Run Middleboro, MA 02346	Female	03/05/1948	(508) 207-7073
	Email --		Primary Language English

Patient Risk Profile
Risk Factors: Decline in mental, emotional, or behavioral status in the past 3 months. Currently taking 5 or more medications. Currently reports exhaustion.

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
J47.9	Bronchiectasis, uncomplicated	03/21/2025

Secondary/Other Diagnosis

Code	Description	Date
J84.9	Interstitial pulmonary disease, unspecified ( )	03/21/2025
J96.21	Acute and chronic respiratory failure with hypoxia ( )	03/21/2025
F41.9	Anxiety disorder, unspecified ( )	03/21/2025
E03.9	Hypothyroidism, unspecified ( )	03/21/2025
E66.811	Obesity, class 1 ( )	03/21/2025
Z68.31	Body mass index [BMI] 310-319, adult ( )	03/21/2025
Z99.81	Dependence on supplemental oxygen ( )	03/21/2025
Z79.82	Long term (current) use of aspirin ( )	03/21/2025
Z79.890	Hormone replacement therapy ( )	03/21/2025
J12.9	Viral pneumonia, unspecified ( )	--

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

Memory: No problems.

Neurological: No problems.

Mood: Anxious.

Behavioral: Appropriate (WNL).

Psychosocial: Patient is a 77-year old female. Patient is alert and oriented x 4. Has occasional reported episodes of anxiety in the past.

Additional Information: --

DME & Supplies
Oxygen. Exam Gloves. Tub/Shower Bench. Walker. Alcohol Pads. , None, None

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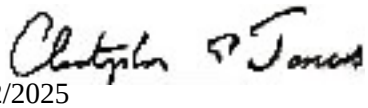
Signature: 
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Prognosis
Fair

Safety Measures
Keep Pathway Clear. Instructed on disaster/emergency plan. Instructed on DME & electrical safety. Instructed on medical gas. Slow Position Change. O2 Precautions. Instructed on mobility safety. Support During Transfer and Ambulation. Emergency Plan Developed. Instructed on safe utilities management. Safety in ADLs. Instructed on safety measures. Proper Position During Meals. Fall Precautions. Use of Assistive Devices. Standard Precautions/Infection Control. , Other: Bleeding precautions, 911/ED protocol, Respiratory Precautions. Cardiac precautions, Skin Breakdown Precaution
, Triage/Risk Code: 2/2, Disaster Code: 2, Comments: Patient/Caregiver verbalize understanding of safety protocols and precautions.

Nutritional Requirements
Regular.

Functional Limitations
Endurance, Dyspnea, Ambulation

Other
--

Activities Permitted	Other
Up as tolerated, Exercise prescribed, Walker	--

Treatments

Medications
Calcium Chews/Vit D/Probiotics Oral 500-12.5-5 MG-MCG-MG 2 Tab(s) 2 chews per day PO
Codeine Sulfate Oral 15 MG 1 Tab(s) 1 tab (15mg) PO QID for 10 days
levoFLOXacin Oral 750 MG 1 Tab(s) One tablet (750mg) PO once a day for 8 days.
Trelegy Ellipta Inhalation 200-62.5-25 MCG/ACT 1 puff inhaled by mouth daily. Rinse mouth after use. (N)
Loratadine Oral 10 MG 1 Tab(s) by mouth once daily as needed for allergy
Aspirin Oral 81 MG 1 Tab(s) by mouth once daily
Levothyroxine Sodium Oral 88 MCG 1 Tab(s) by mouth once daily
Atorvastatin Calcium Oral 40 MG 1 Tab(s) by mouth once daily
busPIRone HCl Oral 5 MG 1 Tab(s) by mouth every 12 hours as needed for anxiety
Famotidine Oral 20 MG 1 Tab(s) by mouth twice a day

Allergies

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

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

Assessment of patient with Bronchiectasis, uncomplicated,Interstitial pulmonary disease, unspecified,Acute and chronic respiratory failure with hypoxia,Anxiety disorder, unspecified Hypothyroidism, unspecified,Obesity, class 1,Body mass index [BMI] 310-319, adult,Dependence on supplemental oxygen,Long term (current) use of aspirin,Hormone replacement therapy.
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

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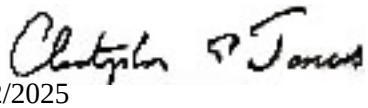
Signature: 
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(Continued) Orders and Treatments

order to leave their place of residence.
Specify: Patient is confined to the home due to illness. The pt needs the aid of a walker, and the assistance of at least one other person.
Patient has a normal inability to leave home.
Leaving home requires a considerable and taxing effort for the patient.
Specify: Patient has a normal inability to leave home. Leaving home requires a considerable and taxing effort for the pt as they suffer from dyspnea at rest and with any activity. Patient used oxygen.

Notify physician of: Temperature greater than (>) NA or less than (<) NA.
Pulse greater than (>) NA or less than (<) NA.
Respirations greater than (>) NA or less than (<) NA.
Systolic BP greater than (>) NA or less than (<) NA.
Diastolic BP greater than (>)NA or less than (<) NA.
O2 Sat less than (<) NA%.
Fasting blood sugar greater than (>) NA or less than (<) NA.
Random blood sugar greater than (>) NA or less than (<) NA.
Weight greater than (>) NA lbs or less than (<) NA lbs.

Frequencies

Skilled Nursing:

5/20/2025 (Tuesday) - 5/31/2025 (Saturday) 3 visits per week for 2 weeks
* Narrative Statement/Order Details: 3 visits a week for 2 weeks, or until pneumonia has resolved and pt is back at baseline.
6/1/2025 (Sunday) - 6/21/2025 (Saturday) 2 visits per week for 3 weeks
* Narrative Statement/Order Details: 2 visits a week for 3 for skilled assessment and education
6/22/2025 (Sunday) - 7/12/2025 (Saturday) 1 visit per week for 3 weeks
* Narrative Statement/Order Details: 1 visits a week for 3 for skilled assessment and education

PRN Orders:
Effective Date: 05/20/2025

Discipline: Skilled Nursing

Number of PRN Visits: 3

Narrative Statement/Order Details: Nursing visits as needed, per change in pts condition.

Additional Orders:
This patient is a 77-year-old female who lives with her husband in a single-family home. Patient with a PMH significant for acute Bronchiectasis exacerbation, interstitial pulmonary disease, acute on chronic hypoxic RF.
Patient presented to Morton Hospital on 2/19/25 with worsening shortness of breath over the last few days. She states that she has needed to increase her supplemental oxygen up to 4 L/ min even during the day due to dyspnea which she refers is worse on exertion. Patient found to have acute flare up of interstitial lung disease likely triggered by viral illness. Patient was treated with systemic corticosteroids/Solu-Medrol 80 Mg 3 times a day. Her response to treatment was slow but steady, her shortness of breath continue to improve slowly, earlier during this hospitalization she used to desaturate to the 80s with minimum ambulation from the bed to the bathroom however with treatment of ILD flare with steroids her shortness of breath is improved and now she is able to ambulate on supplemental O2 2 L via NC maintaining her oxygen saturations. Patient was transferred to HB Shaw Home on 3/8/25 for rehab. DC home 3/20/25.
Patient has completed prednisone taper as of 05/06/2025.
SN to assess respiratory status, identify any signs and symptoms of impaired respiratory 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 and for shortness of breath or s/s of complications. Patient SOB after minimal

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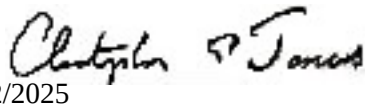
Signature: 
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(Continued) Orders and Treatments

exertion, requiring O2 management at home.
05/12/2025 pt had chest x-ray due to increasing SOB, fevers, malaise, cough. Chest x-ray showed pneumonia in LLL. Pt on levofloxacin 750mg once daily for 8 days & Codeine sulfate 15mg PO 4x daily for 10 days. Pt currently using 4-5L O2 via NC while active. Pt has a follow up with primary care thursday 05/22/2025.
Patient is homebound, decreased strength and endurance, dyspnea with minimal exertion, requires assistance of 1 person and device to leave home. Skilled nursing required to address respiratory status and monitor for changes in lung sounds related to lung disease. SN needed for education on medication compliance including teaching use, effect and dosing, skilled observation and assessment of resp and teaching to include resp disease process, s/sx's to report, importance of adhering to diet. Education on safety and fall prevention.
VFO change for SN 3 visits x 2w, 2 visits x 3w, 1 visit x 3w .
PT and OT on hold per patient until pneumonia has resolved.

SN Interventions
SN to instruct the Patient & Caregiver on factors that contribute to SOB, including avoiding outdoors on poor air quality days. Avoid leaving windows open when outside temperature is above 80
SN to assess respiratory status, identify any signs and symptoms of impaired respiratory function.
SN to instruct patient on diseaseprocess, 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 and for shortness of breath or s/s of complications
SN to instruct the Patient on methods to recognize pulmonary dysfunction and relieve complications
SN to instruct patient on energy conserving measures including frequent rest periods, small frequent meals, avoiding large meals/overeating, and controlling stress
SN to instruct the Patient on factors that contribute to SOB, including avoiding outdoors on poor air quality days. Avoid leaving windows open when outside temperature is above 80
Teach the patient how to clean and maintain the equipment (e.g., changing the nasal cannula regularly, cleaning the mask and tubing).
Instruct on the use of portable oxygen concentrators, including charging the unit, carrying it safely, and adjusting settings.
Educate the patient and family members on the importance of keeping oxygen equipment away from open flames, heat sources, and any items that may cause a fire (e.g., cigarettes, candles, stoves).
SN to instruct patient/caregiver regarding self- management of oxygen therapy, perform risk assessment and administer O2 at 2 liters per minute via nasal cannula
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.
SN to perform complete physical assessment each visit with emphasis on Bronchiectasis. SN to assess other comorbidities including Interstitial pulmonary disease and other conditions that present themselves during this episode of care. SN to recognize and intervene to minimize complications; notify physician immediately of any potential problems that impede completion of patient recovery and desired goals.
SN to assess and monitor vital signs every visit and report to MD any deviations from the normal parameters.
SN to assess for signs and symptoms of infection and instruct patient/caregiver on measures to prevent infection including, universal precautions, mouth care, skin care, and environmental sanitation.
SN to instruct patient/caregiver on regular diet and to assess patient for diet compliance to prevent complications.
SN to instruct patient/caregiver on fall prevention and safety measures such as wearing proper footwear and using prescribed assistive device(s) when ambulating; safe transfers, removing clutter and instructing on the importance of adequate lighting in patient's area.
Patient identified to be at risk for pressure ulcer development. SN to provide skilled assessment, identify and mitigate risk factors, provide patient/caregiver instruction and reinforcement of teaching to prevent pressure ulcer development.

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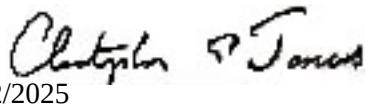
Signature: 
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Goals and Outcomes

SN Goals
Patient will verbalize understanding on energy conservation techniques By the end of the episode (Goal Term: long, Target Date: 7/18/25)
Patient and caregiver will verbalize understanding of factors that contribute to shortness of breath. By the end of the episode (Goal Term: long, Target Date: 7/18/25)
Patient will Verbalized independent with oxygen equipment by the end of the episode (Goal Term: long, Target Date: 7/18/25)
Patient & Caregiver Will verbalize understanding of medication regimen, dose, root, frequency, indications and side effects by the end of the episode (Goal Term: long, Target Date: 7/18/25)
Patient will understand the disease process, meds, and when to notify MD with complications/concerns related to the primary diagnosis by end of the certification. (Goal Term: long, Target Date: 7/18/25)
Patient's vital signs will remain within parameters throughout the certification period. (Goal Term: long, Target Date: 7/18/25)
Patient/caregiver will demonstrate proper infection precautions and prevent the spread of infection by 04/19/2025. (Goal Term: long, Target Date: 7/18/25)
Patient/caregiver will verbalize understanding and patient will exhibit compliance with prescribed diet throughout the episode of care. (Goal Term: long, Target Date: 7/18/25)
Patient/PCG will verbalize understanding of instructions on fall prevention and safety measures by 04/19/2025. (Goal Term: long, Target Date: 7/18/25)
Patient/caregiver will demonstrate measures to prevent skin breakdown throughout the episode of care. (Goal Term: long, Target Date: 7/18/25)

Rehab potential: Good 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 caregiver.
Discharge patient to self care.
Discharge when goals met.
Discharge when patient is independent in management of medical needs.

Nurse Signature and Date of Verbal SOC Where Applicable	**Date**
Digitally Signed by: Keryl Dorr , RN	05/20/2025

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**
JONCAS, CHRISTOPHER MD	203 PLYMOUTH AVE FALL RIVER, MA 02721	(508) 235-5445
NPI		**Fax Number**
1336136456		(508) 235-5594

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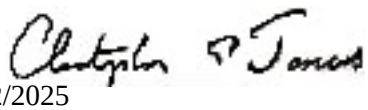
Signature: 
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