Patient Information

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.
100015466053	12/29/2023	From: 12/18/2025 To: 02/15/2026	1269

Patient's Name and Address	Gender	Date of Birth	Phone Number
FIGUEROA, ROSA 28 Jewett Street Apt 1 LOWELL, MA 01850	Female	05/24/1964	(978) 728-2544
	Email --		Primary Language Spanish

Patient Risk Profile

- H/O depression, educate the patient on the s/sx of decompensation and reporting symptoms before they get worse and on effective coping skills to alleviate symptoms.
- Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise), Assess client and educate client on the importance of complying with diet and meds.
- Currently taking 5 or more medications, assess patient on the effects of meds prescribed and update MD on the effectiveness of the meds prescribed.
- Currently reports exhaustion. Assess patient on functional status and instruct patient on reporting symptoms

Clinical Data

Clinical Manager	Branch Name and Address	Phone Number
Muiruri, Peninnah W	Better Life at Home 173 Pine Street Lowell, MA 01851-3112	(978) 710-5417
Provider Number - Medicare Number 1093089039		**Fax Number** (888) 206-4001

Primary Diagnosis

Code	Description	Date
J45.21	Mild intermittent asthma with (acute) exacerbation (E)	11/02/2023

Secondary/Other Diagnosis

Code	Description	Date
M51.06	Intervertebral disc disorders with myelopathy, lumbar region (E)	11/02/2023
F33.3	Major depressv disorder, recurrent, severe w psych symptoms (E)	11/02/2023
F41.9	Anxiety disorder, unspecified (E)	12/28/2023
K21.9	Gastro-esophageal reflux disease without esophagitis (E)	12/28/2023
G43.001	Migraine w/o aura, not intractable, with status migrainosus (E)	12/28/2023
I15.8	Other secondary hypertension (E)	12/28/2023

Mental Status

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

Memory: Forgetful.

Neurological: Spasms, Tremors, Headaches.

Mood: Depressed, Anxious.

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

Psychosocial: Pt living alone, with 2 dogs and cats.unable to safely and effectively manage her medical needs requires SN assistance with medication management,to educate her on disease process to prevent decompensation and hospitalization. hha services to assist her with ADLS.

(Continued) Mental Status

Additional Information: --

DME & Supplies
Cane. Elevated Toilet Seat. Grab Bars. Exam Gloves. Tub/Shower Bench.

Prognosis
Fair

Safety Measures
Keep Pathway Clear. Instructed on disaster/emergency plan. Instructed on mobility safety. Safety in ADLs. Instructed on safety measures. Proper Position During Meals. Standard Precautions/Infection Control. , Triage/Risk Code: 2, Disaster Code: 3

Nutritional Requirements
No Added Salt. Heart Healthy. Low Cholesterol. Low Fat.

Functional Limitations
Endurance, Ambulation, Other

Other
Pain

Activities Permitted	Other
Up as tolerated, Independent at home, Cane	--

Treatments

Medications
Diclofenac Sodium Oral 50 MG 1 tab Tab(s) 1 tab every 6 hours as needed for pain
Flonase Nasal 50 MCG/ACT 1 ml 1-2 sprays each nastril twice a day
hydrOXYzine HCl Oral 50 MG 1 Tab(s) 50 MG three times a day.
Naprosyn Oral 500 MG 1 Tab(s) po bid prn pain
Melatonin Oral 5 MG 1 Tab(s) 5mg PO q hs
Ventolin HFA Inhalation 108 (90 Base) MCG/ACT 1 2 puffs bid
Haloperidol Oral 0.5 MG 1 Tab(s) bid in am and pm (Intructions) Take 1 tablet in am and 2 tablets at HS
traZODone HCl Oral 100 MG 1 Tab(s) Q HS
Benztropine Mesylate Oral 1 MG 1 Tab(s) daily in am
Flovent HFA Inhalation 110 MCG/ACT 2 PUFFS BID IN AM AND PM
Lisinopril Oral 20 MG 1 Tab(s) Q AM
FLUoxetine HCl Oral 20 MG 3 Cap(s) Q AM
Aspirin Oral 81 MG 1 Tab(s) daily in am

Allergies

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

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

SN: 1visit/week x 9 weeks, .
HHA: 1hr/day/4x/week x 4 weeks, .

(Continued) Orders and Treatments

MAV- 2 visits/week from 12/17/2025-02/07/2026
MAV- 1 visit/week from 02/08/2026-02/14/2026.
Assessment of patient with Mild intermittent asthma with (acute) exacerbation,Intervertebral disc disorders with myelopathy, lumbar region,Major depressv disorder, recurrent, severe w psych symptoms,Anxiety disorder, unspecified,Gastro-esophageal reflux disease without esophagitis,Migraine w/o aura, not intractable, with status migrainosus,Other secondary hypertension.
Homebound Status: Homebound: No

Notify physician of: Temperature greater than (>) 100.5 or less than (<) 94.
Pulse greater than (>) 100 or less than (<) 60.
Respirations greater than (>) 24 or less than (<) 14.
Systolic BP greater than (>) 160 or less than (<) 90.
Diastolic BP greater than (>)90 or less than (<) 60.
O2 Sat less than (<) 90%.

SN Interventions
SN to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and/or hot/cold pa
Patient will verbalize understanding of proper use of pain medication by 02/25/2024
SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit
SN to assess patient's willingness to take pain medications and/or barriers to compliance, e.g., patient is unable to tolerate side effects such as dr
SN to instruct the inhalers proper use of nebulizer/inhaler, and assess return demonstration
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 100
SN to determine if the Patient is able to identify the correct dose, route, and frequency of each medication
SN to instruct patient on energy conserving measures including frequent rest periods, small frequent meals, avoiding large meals/overeating, and controlling stress
SN to assess patient's communication skills every visit SN to assess patients mood and mental status q visit SN to educate patient on the s/sx decompensation q visit SN to educate patient on the use of PRN medication to alleviate symptoms of a anxiety.
SN to instruct caregiver on orientation techniques to use when patient becomes disoriented
SN to instruct the Patient on medication regimen dose, indications, side effects, and interactions
SN to instruct the Patient on signs and symptoms of ineffective drug therapy to report to SN or physician
SN to establish reminders to alert patient to take medications at correct times
SN to instruct patient on pursed lip breathing techniques
SN to assess for changes in neurological status every visit

Goals and Outcomes

SN Goals
Patient will verbalize understanding of proper use of pain medication by pt will verbalize proper use pf pain medication. during the end of episode (Goal Term: long, Target Date: 2/15/26)
Patient will achieve pain level less than 2 within pt will verbalize pain less than 2/10 (Goal Term: long, Target Date: 2/15/26)
Patient will demonstrate proper use of inhalers by 02/15/2026 (Goal Term: long, Target Date: 2/15/26)
Patient and caregiver will verbalize an understanding of factors that contribute to shortness of breath by:02/15/2026 (Goal Term: long, Target Date: 2/15/26)
pt will verbolize understanding of medication regiment. will verbalize understanding of medication regimen, dose, route, frequency, indications, and side effects by 02/15/2026 (Goal Term: long, Target Date: 2/15/26)
Patient will verbalize an understanding of energy conserving measures by 02/15/2026 (Goal Term: long, Target Date: 2/15/26)

(Continued) Goals and Outcomes

Patient will verbalize understanding of need to control abusive behavior Patient will verbalize effective coping skills q visit. Patient will remain safe at home and in the community during the episode. Patient will verbalize the use of emergency numbers when feeling unsafe during the episode. (Goal Term: long, Target Date: 2/15/26)
patient will verbalize understanding of medication regimen, dose, route, frequency, indications, and side effects by 02/15/2026 (Goal Term: long, Target Date: 2/15/26)
Patient will demonstrate proper pursed lip breathing techniques by 02/15/2026 (Goal Term: long, Target Date: 2/15/26)
Patient will remain free from increased confusion during the episode (Goal Term: long, Target Date: 2/15/26)

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 patient to self care.
Discharge when goals met.
Discharge when reliable caregiver available to assist with patient's medical needs.
Discharge when patient is independent in management of medical needs.

Nurse Signature and Date of Verbal SOC Where Applicable	**Date**
Digitally Signed by: Eunice W Muiruri , RN	12/13/2025

I certify/ recertify that this patient is not 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**
MARCOUX, KATHLEEN NP	161 Jackson St LOWELL, MA 01852	(978) 441-1700
NPI		**Fax Number**
1972040236		(978) 221-6216

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