Loureiro, Robert P
90 year old Male

MRN: **2114147**
Date of Birth: **11/9/1934**

Agency Information

Southcoast Visiting Nurse Association Inc.
200 Mill Road
Fairhaven, MA 02719-5252
Ph: 508-973-3200
Fx: 508-973-3417

Plan of Care (1106391) Submitted

Home Health Plan of Care 6/12/25

Plan ID: 308195

Effective from: 6/12/2025 Effective to: 8/10/2025
Last Updated On: 6/30/2025

Patient Information

(M0040) Name	Current Address	(M0066) Date of Birth	(M0069) Sex	(M0063) HI Claim No.
Loureiro, Robert P	886 Terry Ln New Bedford, MA 02745-3306 508-995-9624	11/9/1934	Male	3XX1YJ1XD99

(M0030) Start of Care Date	(M0104) Referral Date	Certification Period	MRN	(M0050-M0060) Assessment Address
6/12/2025	6/10/2025	6/12/2025 - 8/10/2025	2114147	MA 027453306

Agency Information

(M0010) CMS Certification Number	Name	Address	Telephone Number
22-7101	Southcoast Visiting Nurse Association Inc.	200 Mill Road Fairhaven, Massachusetts 02719-5252	Ph: 508-973-3200 Fax: 508-973-3417

Medications

Prescriptions and Patient-Reported

Name - (N)ew/(C)hanged	Start Date	End Date
acetaminophen 500 MG tablet - (C) Sig: Take 1 tablet (500 mg total) by mouth every 8 (eight) hours as needed for moderate pain (4-6) Route: Oral Authorizing Provider: John Craford, MD Discontinued: 6/23/2025 at 1241	10/14/2024	6/23/2025
acetaminophen 500 MG tablet - (C) Sig: Take 2 tablets (1,000 mg total) by mouth every 8 (eight) hours for 10 days Route: Oral Authorizing Provider: Theresa Souza, NP	6/23/2025	7/3/2025
cholecalciferol (VITAMIN D3) 50 mcg (2000 units) tablet - (C) Sig: Take 1 tablet (2,000 Units total) by mouth daily Route: Oral Authorizing Provider: Historical Provider, MD	—	—
Cyanocobalamin (Vitamin B12) 1000 MCG TBCR - (C) Sig: Take 1 tablet (1,000 mcg total) by mouth daily Route: Oral Authorizing Provider: Historical Provider, MD	6/12/2025	—
docusate sodium 100 MG capsule - (C) Sig: Take 1 capsule (100 mg total) by mouth daily Route: Oral Authorizing Provider: Arielle L Adrien-Jean, MD	11/6/2024	3/24/2026
furosemide (LASIX) 40 MG tablet - (C) Sig: Take 0.5 tablets (20 mg total) by mouth daily Route: Oral Authorizing Provider: Historical Provider, MD	—	—

furosemide 20 MG tablet - (C) (Removed: 6/19/2025) Sig: Take 1 tablet (20 mg total) by mouth daily Route: Oral Authorizing Provider: Thomas J Doyle, MD Discontinued: 6/15/2025 at 1902	6/11/2025	6/15/2025
magnesium oxide (MAG-OX) 400 MG tablet - (C) Sig: Take 1 tablet (400 mg total) by mouth 2 (two) times a day Route: Oral Authorizing Provider: Thomas J Doyle, MD	6/10/2025	7/10/2025
metoprolol succinate 50 MG extended release tablet - (C) Sig: Take 1 tablet (50 mg total) by mouth 2 (two) times a day Route: Oral Authorizing Provider: Thomas J Doyle, MD	6/10/2025	7/10/2025
naloxone 4 mg/0.1 mL nasal spray liquid - (C) Sig: 1 spray (4 mg total) to one nostril as needed for opioid reversal . May repeat every 2 to 3 minutes if no response. Alternate nostrils. Route: Alternating Nares Authorizing Provider: Thomas J Doyle, MD	6/10/2025	7/10/2025
nitroglycerin (NITROSTAT) 0.4 MG sublingual tablet - (C) Sig: Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain Route: Sublingual Authorizing Provider: Gregory D Russell, MD	9/9/2022	—
oxyCODONE (ROXICODONE) 5 mg immediate release tablet - (C) (Removed: 6/27/2025) Sig: Take 0.5 tablets (2.5 mg total) by mouth every 4 (four) hours as needed for moderate pain (4-6) for up to 10 days Max Daily Amount: 15 mg Route: Oral Authorizing Provider: Thomas J Doyle, MD Discontinued: 6/23/2025 at 0955	6/10/2025	6/23/2025
oxyCODONE (ROXICODONE) 5 mg immediate release tablet - (C) Sig: Take 0.5 tablets (2.5 mg total) by mouth every 4 (four) hours as needed for moderate pain (4-6) or severe pain (7-10) for up to 20 doses Max Daily Amount: 15 mg Route: Oral Authorizing Provider: Theresa Souza, NP	6/23/2025	—
pantoprazole (PROTONIX) 40 MG delayed release EC tablet - (C) Sig: Take 1 tablet (40 mg total) by mouth 2 (two) times a day before breakfast and dinner Route: Oral Authorizing Provider: Vicki Saint-Paine, NP	3/24/2025	—
polyethylene glycol 3350 17 g powder for oral solution packet - (C) Sig: Dissolve contents of 17 g as directed and take by mouth daily Route: Oral Authorizing Provider: Arielle L Adrien-Jean, MD Discontinued: 6/23/2025 at 1241	11/6/2024	6/23/2025
polyethylene glycol 3350 17 g powder for oral solution packet - (C) Sig: Dissolve contents of 17 g as directed and take by mouth 2 (two) times a day Route: Oral Authorizing Provider: Theresa Souza, NP	6/23/2025	7/23/2025
simvastatin (ZOCOR) 40 MG tablet - (C) Sig: Take 1 tablet (40 mg total) by mouth daily Route: Oral Authorizing Provider: Historical Provider, MD	10/21/2014	—
tamsulosin (FLOMAX) 0.4 MG capsule - (C) Sig: Take 1 capsule (0.4 mg total) by mouth daily Route: Oral Authorizing Provider: Historical Provider, MD	11/13/2024	—

Diagnoses

(M1021) Principal Diagnosis

ICD	Description	Date	Flag
I47.10	Supraventricular tachycardia, unspecified	6/12/2025	—

(M1023) Other Pertinent Diagnoses

ICD	Description	Date	Flag
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	6/12/2025	—
I50.33	Acute on chronic diastolic (congestive) heart failure	6/12/2025	—
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	6/12/2025	—
N17.9	Acute kidney failure, unspecified	6/12/2025	—
N18.32	Chronic kidney disease, stage 3b	6/12/2025	—

C67.9	Malignant neoplasm of bladder, unspecified	6/12/2025	—
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris	6/12/2025	—
M25.512	Pain in left shoulder	6/12/2025	—
F43.20	Adjustment disorder, unspecified	6/12/2025	—
E87.6	Hypokalemia	6/12/2025	—
E87.0	Hyperosmolality and hypernatremia	6/12/2025	—
E83.42	Hypomagnesemia	6/12/2025	—
E78.00	Pure hypercholesterolemia, unspecified	6/12/2025	—
G89.29	Other chronic pain	6/12/2025	—
M48.00	Spinal stenosis, site unspecified	6/12/2025	—
N40.0	Benign prostatic hyperplasia without lower urinary tract symptoms	6/12/2025	—
M85.80	Other specified disorders of bone density and structure, unspecified site	6/12/2025	—
K21.9	Gastro-esophageal reflux disease without esophagitis	6/12/2025	—
Z87.01	Personal history of pneumonia (recurrent)	6/12/2025	—
Z91.81	History of falling	6/12/2025	—
Z87.11	Personal history of peptic ulcer disease	6/12/2025	—
Z95.5	Presence of coronary angioplasty implant and graft	6/12/2025	—
Z55.6	Problems related to health literacy	6/12/2025	—
Z87.442	Personal history of urinary calculi	6/12/2025	—

Procedures

No procedures on file.

Durable Medical Equipment

Name	Start Date	End Date	Comments
Quad cane	6/12/2025	—	—
Front wheeled walker	6/12/2025	—	—
Wall grab bars	6/12/2025	—	at base of inside stairs and at top of back outside stairs to enter home
Bath chair	6/12/2025	—	—

Safety & Nutrition as of 6/12/2025 OASIS assessment

Safety Measures
Adequate emergency plan, Adequate lighting, Ambulate only with assistance, Correct use of support devices, Phone access, Proper medication use, Ramps/hand railings, Smoke detectors

Nutritional Requirements
Diabetic diet, Low sodium diet, Other - 2L fluid restriction

Allergies as of 6/30/2025

	Severity	Noted	Reaction Type	Reactions
Lisinopril	Medium	05/30/2019		Cough
Gluten - Food Allergy	Not Specified	08/27/2022		GI Intolerance
Amoxicillin	Low	11/12/2014		Itching
Famotidine	Low	03/24/2025		Anxiety

Functional Assessment as of 6/12/2025 OASIS assessment

Functional Limitations
Hearing, Endurance, Ambulation

Activities Permitted
Up as Tolerated, Cane, Walker

Prognosis
Fair (3/5)

Mental Status as of 6/12/2025 assessment

C0100 - Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
1. Yes

C0200 - Repetition of Three Words
Ask patient: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue and bed. Now tell me the three words."</br>Number of words repeated after first attempt
3. Three

C0300A - Temporal Orientation to Year
3. Correct

C0300B - Temporal Orientation to Month
2. Accurate within 5 days

C0300C - Temporal Orientation to Day
1. Correct

C0400A - Recall "Sock"
2. Yes, no cue required

C0400B - Recall "Blue"
2. Yes, no cue required

C0400C - Recall "Bed"
2. Yes, no cue required

C0500 - BIMS Summary Score
15 (Cognitively intact)

C1310A - Acute Onset of Mental Status Change
0. No

C1310B - Inattention
0. Behavior not present

C1310C - Disorganized Thinking
0. Behavior not present

C1310D - Altered Level of Consciousness
0. Behavior not present

M1700 - Cognitive Functioning
Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.

M1710 - When Confused (Reported or Observed Within the Last 14 Days)
When Confused (Reported or Observed Within the Last 14 Days):
1 - In new or complex situations only

M1720 - When Anxious (Reported or Observed Within the Last 14 Days)

When Anxious (Reported or Observed Within the Last 14 Days):

0 - None of the time

D0150 - Patient Mood Interview (PHQ-2 to 9)

A. Little interest or pleasure in doing things:

1. Symptom Presence: 0 - No
2. Symptom Frequency: 0 - Never or 1 day

B. Feeling down, depressed, or hopeless:

1. Symptom Presence: 0 - No
2. Symptom Frequency: 0 - Never or 1 day

C. Trouble falling or staying asleep, or sleeping too much:

1. Symptom Presence: ^ - Skipped
2. Symptom Frequency: ^ - Skipped

D. Feeling tired or having little energy:

1. Symptom Presence: ^ - Skipped
2. Symptom Frequency: ^ - Skipped

E. Poor appetite or overeating:

1. Symptom Presence: ^ - Skipped
2. Symptom Frequency: ^ - Skipped

F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down:

1. Symptom Presence: ^ - Skipped
2. Symptom Frequency: ^ - Skipped

G. Trouble concentrating on things, such as reading the newspaper or watching television:

1. Symptom Presence: ^ - Skipped
2. Symptom Frequency: ^ - Skipped

H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual:

1. Symptom Presence: ^ - Skipped
2. Symptom Frequency: ^ - Skipped

I. Thoughts that you would be better off dead, or of hurting yourself in some way:

1. Symptom Presence: ^ - Skipped
2. Symptom Frequency: ^ - Skipped

D0160 - Total Severity Score

0 (Minimal depression)

D0700 - Social Isolation

How often do you feel lonely or isolated from those around you?

0. Never

M1740 - Cognitive, Behavioral, and Psychiatric Symptoms

Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed):

7 - None of the above behaviors demonstrated

M1745 - Frequency of Disruptive Behavior Symptoms (Reported or Observed)

Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

0 - Never

Mental Status

Oriented, Forgetful

Visit Sets

Occupational Therapy

Visits

Visits	Dates
1 visit every 60 days for 60 days	6/12/2025 to 8/10/2025 (discontinued as of 6/19/2025)
Comments: 17(A6,B6,C2,D3) 6/12 RECENT FALL WITH INJURY/HIGH FALL RISK, CHF, BLADDER CA - PT HAS SEVERE BILATERAL CARPAL TUNNEL, WILL NEED FINE MOTOR THERAPY	
1 visit every 60 days for 45 days	6/27/2025 to 8/10/2025
Comments: 17(A6,B6,C2,D3) 6/27 RECENT FALL (6/7) WITH INJURY/HIGH FALL RISK, CHF, BLADDER CA - PT HAS SEVERE BILATERAL CARPAL TUNNEL, WILL NEED FINE MOTOR THERAPY	

Physical Therapy

Visits

Visits	Dates
1 visit every 60 days for 60 days	6/12/2025 to 8/10/2025 (discontinued as of 6/19/2025)
Comments: 17(A6,B6,C2,D3) 6/12 RECENT FALL WITH INJURY/HIGH FALL RISK, CHF, BLADDER CA	
1 visit every 60 days for 45 days	6/27/2025 to 8/10/2025
Comments: 17(A6,B6,C2,D3) 6/27 RECENT FALL (6/7) WITH INJURY/HIGH FALL RISK, CHF, BLADDER CA	

Skilled Nursing

Visits

Visits	Dates
1 to 5 visits as needed	6/12/2025 to 8/10/2025 (discontinued as of 6/19/2025)
Comments: PRN	
2 visits every week for 1 week	6/15/2025 to 6/21/2025 (discontinued as of 6/19/2025)
1 visit every week for 7 weeks	6/22/2025 to 8/9/2025 (discontinued as of 6/22/2025)
1 visit every day for 1 day	6/27/2025 to 6/27/2025
1 to 5 visits as needed	6/27/2025 to 8/10/2025
Comments: PRN	
2 visits every week for 1 week	6/29/2025 to 7/5/2025
1 visit every week for 5 weeks	7/6/2025 to 8/9/2025

Care Plan

Skilled Nursing

Problem: Cardiac

Starting: 6/12/2025

Alt in Cardiac Status-CHF,HTN, other Cardiac disease

Goal: Patient/caregiver will verbalize and demonstrate understanding of disease management, avoiding ED visits/rehospitalizations and following appropriate measures during a cardiopulmonary exacerbation.

Starting: 6/12/2025 Most recent outcome: Progressing

Pt/caregiver will verbalize/demonstrate effective management of cardiac disease including steps to take

with exacerbation
Pt/caregiver will verbalize/demonstrate ability to identify/report symptoms to HCP including vitals, fluid overload, dehydration, chest pain, dyspnea, & barriers to manage disease

- **Intervention: Assess and Instruct on Appropriate Use of Devices/Equipment**
  Starting: 6/12/2025 Frequency: Each Visit
  walker
  cane
  BP cuff
  scale
  oximeter
- **Intervention: Assess and Instruct on Dietary Effects on Cardiac Diet**
  Starting: 6/12/2025 Frequency: Each Visit
  Reading food labels
  Limiting fluid intake
  Specialty diet
- **Intervention: Assess and Instruct on Edema Management**
  Starting: 6/12/2025 Frequency: Each Visit
  Teach self exam including but not limited to daily weight, swelling of face, abdomen and feet.
- **Intervention: Assess and Instruct on Fluid Restrictions**
  Starting: 6/12/2025 Frequency: Each Visit
  2L
- **Intervention: Assess and Instruct on S/S of Chest Pain Including Steps to Take with Chest Pain and When to Contact HCP**
  Starting: 6/12/2025 Frequency: Each Visit
- **Intervention: Assess and Instruct on Self-Monitoring of Vital Signs Including Daily Weight and Keeping A Vital Signs Log**
  Starting: 6/12/2025 Frequency: Each Visit
- **Intervention: Instruct on CHF disease process**
  Starting: 6/12/2025 Frequency: Each Visit

Problem: Depression
Starting: 6/30/2025
Depression Management

Goal: Stabilization of symptoms using medication compliance, disease management, coping strategies and community resources.
Starting: 6/30/2025
The patient will understand the disease of depression

- **Intervention: Assess and Instruct on Disease Process and Management Techniques**
  Starting: 6/30/2025 Frequency: Each Visit
  Pt/cg will verbalize understanding of: Depression - Assess and instruct in disease process and management techniques

Problem: Diabetes
Starting: 6/12/2025
Diabetes Management

Goal: Compliance with Medication, Diet, Glucometer, Foot Care. Independent with signs/symptoms to report to HCP.
Starting: 6/12/2025 Most recent outcome: Progressing
The patient/caregiver will be instructed in the following and verbalize s/s to report to HCP:

Diabetic footcare including proper footwear
Daily inspection and identification of LE lesions
S/s of hyper/hypoglycemia
Compliance with diabetic med regim en, use of glucometer and diabetic diet
Blood glucose levels outside of established parameters

- **Intervention: Assess and Instruct in Ability/Willingness to Participate in Care**
  Starting: 6/12/2025 Frequency: Each Visit

Glucometer use: testing, recording, reading, reporting, hi/low solution controls and matching glucometer chip (if glucometer requires chip)
Relationship between blood sugar and stress (sick day) need to assess blood sugar more frequently, caution hyp oglycemia and or hyperglycemia, need to call HCP to obtain instructions regarding medications, need to continue to contact HCP with unmanaged blood sugar levels throughout the day
S/s of hyper and hypoglycemia (including emergency plan) steps to take an d when to contact HCP
Longterm effects of hyperglycemia
Arrange medical appointments, such as eye exams, labs for A1C, podiatry
Diabetic activity - 30 to 60 minutes of daily activity
Report noncompliance to HCP

Intervention: Assess for Complications
Starting: 6/12/2025 Frequency: Each Visit
i.e.vision changes, headaches, cardiac symptoms, weight gain or loss, open wounds

Intervention: Instruct Patient/Caregiver to Monitor for the Presence of Skin Lesions on the Lower Extremities
Starting: 6/12/2025 Frequency: Each Visit
Instruct patient/caregiver to monitor for the presence of skin lesions on the lower extremities on a daily basis

Intervention: Instruct Proper Foot Care
Starting: 6/12/2025 Frequency: Each Visit
Inspect feet daily. Use mirror if needed.
Wash feet daily with soap and luke warm water, rinse, pat dry, apply lotion to feet except between toes, apply socks and proper protective footwear.
Do not walk barefoot.

Problem: Fall Prevention
Starting: 6/12/2025
At Risk for Falls - Fall Prevention

Goal: Demonstrate ability to follow strategies minimizing fall risk; verbalize fall risk awareness due to meds/sensory deficits and environmental factors.
Starting: 6/12/2025 Most recent outcome: Progressing
Patient will demonstrate safe gait with or without a device.
Patient/caregiver will verbalize an awareness of the risk for falls due to medications, sensory deficits, environmental factors, or other causes .
Patient/caregiver will demonstrate strateg ies to prevent falls including modification of environment.

Intervention: Assess and Instruct on Appropriate Use of Devices/Equipment
Starting: 6/12/2025 Frequency: Each Visit
walker
cane
BP cuff
scale
oximeter

Intervention: Assess and Instruct on Physiological Fall Risk Factors and Prevention
Starting: 6/12/2025 Frequency: Each Visit
orthostatic hypotension
dyspnea
anxiety
pain
breathing techniques
relaxation techniques
stand/wait/walk
do not rush to step

Intervention: Assess/Instruct Regarding Fall Risk Factors and Prevention
Starting: 6/12/2025 Frequency: Each Visit
adequate lighting in the home
safe seating, chairs with arms rests and that are high enough to support standing
keep necessities within reach such as telephone, commode, snacks, beverages, etc

appropriate footwear, including appropriate size, non sk id and supportive
non skid, stable stairs
review/removal of all trip hazards such as placement of electrical cords and scatter rugs

Intervention: Report Falls to HCP
Starting: 6/12/2025 Frequency: Each Visit
reported by patient
observed by staff

Problem: General Home Safety
Starting: 6/12/2025
Alteration in Safety

Goal: Demonstrate safe use of medical/assistive equipment, strategies for reducing home hazards i.e. smoke detectors, evacuation plan; ability to access community services.
Starting: 6/12/2025 Most recent outcome: Progressing
Patient/caregiver will demonstrate strategies reducing home hazards
Patient/caregiver will verbalize and demonstrate safe use of medical equipment

Intervention: Assess for Safety Issues
Starting: 6/12/2025 Frequency: Each Visit
Assess lack of smoke detectors, fire extinguisher, evacuation plan. Damaged electrical cords, space heaters and other fire hazards

Intervention: Instruct Strategies to Reduce Hazards
Starting: 6/12/2025 Frequency: Each Visit
scatter rugs
electrical cords
night lights
clear pathways
avoid clutter
railings
nonskid footwear
lighting

Problem: General Skin / Integumentary
Starting: 6/12/2025
Alteration in Integumentary status (actual and/or risk for)

Goal: Free from integumentary complications; able to demonstrate interventions/dietary measures to promote healthy skin.
Starting: 6/12/2025 Most recent outcome: Progressing
Pt will be free from integumentary complications

Intervention: Assess and Instruct on Risk of and on Methods to Prevent Skin Breakdown
Starting: 6/12/2025 Frequency: Each Visit
Patient specific risk factors

Problem: LPN Supervision
Starting: 6/12/2025
Supervision of LPN

Goal: Provide appropriate supervision in the delivery of nursing services.
Starting: 6/12/2025 Most recent outcome: Progressing
EVERY 30 DAYS

Intervention: Perform LPN supervisory visit
Starting: 6/12/2025 Frequency: Each Visit
EVERY 30 DAYS

Problem: Medication Management and Safety
Starting: 6/12/2025
Medication Management and Safety

Goal: Patient/caregiver will verbalize and demonstrate understanding of medication management, reconciliation, schedule, purpose and side effects. Will also demonstrate ability to take medications as prescribed and ability to re-order medications.
Starting: 6/12/2025 Most recent outcome: Progressing

Patient/caregiver will demonstrate ability to take medications as prescribed and re order medications from the pharmacy
Patient/caregiver will verbalize understanding of medication management, reconciliation, schedule, purpose, side effects & symptoms to report to HCP.

Intervention: Assess Medications
Starting: 6/12/2025 Frequency: Each Visit
Medication access - Assess vision, fine motor skills and/or other barriers in accessing medications.
Medications - Assess new, changed and/or missing medications.
Impact of medications on nutrition.
Compliance with medication schedule

Intervention: Assess and Instruct on Medications and Medication Management
Starting: 6/12/2025 Frequency: Each Visit
Pt/cg will verbalize understanding of:

Medication - one each visit until all medications taught.
Name, purpose, dose, schedule, side/adverse effects.
Storage and expiration date monitoring.
Medication reconciliation.
Maintain updated med list.
Integrate medication regimen into daily routine.

Problem: Pain
Starting: 6/12/2025
Alteration in comfort- Pain

Goal: Achieve acceptable levels of pain, independence with strategies for breakthrough pain and symptoms to report to HCP.
Starting: 6/12/2025 Most recent outcome: Progressing
Identify barriers to adequate pain management
Acceptable level of pain will be achieved
Pt/caregiver will verbalize plan to manage breakthrough pain
Pt will demonstrate proper use of pain meds and will verbalize side effects, signs, symptoms, and complications to report to HCP

Intervention: Assess Effectiveness of Pain Medications
Starting: 6/12/2025 Frequency: Each Visit
Assess effectiveness of pain medication each visit until acceptable level is achieved, including over the counter medications.

Intervention: Assess and Instruct on Patient's Level of Pain Using Appropriate Pain Scale
Starting: 6/12/2025 Frequency: Each Visit
Using pain scale every visit until acceptable level is achieved
For breakthrough pain management, teach avoid allowing pain to go above a 5 on 0-10 scale
Teach use of pain scale

Intervention: Instruct in Pain Management Strategies
Starting: 6/12/2025 Frequency: Each Visit
Non-pharmacological strategies, such as rest, repositioning and distraction to achieve acceptable level of pain

Intervention: Instruct in Pain Medication and Strategies to Avoid Bowel Complications
Starting: 6/12/2025 Frequency: Each Visit

Problem: Telemonitor Management
Starting: 6/12/2025
Telemonitor Management

Goal: Patient/caregiver will verbalize and demonstrate ability to report changes related to telemonitoring maintaining patient at home and reducing ED visits/rehospitalizations.
Starting: 6/12/2025 Most recent outcome: Progressing
Pt/caregiver will verbalize/demonstrate self-assessment of VS, daily monitoring/logging of VS, symptoms to report to HCP
Pt/caregiver will demonstrate safe and proper use of the telemonitor to assist in disease management

and prevention

Intervention: Teach Patient Vital Signs Assessment

Starting: 6/12/2025 Frequency: Each Visit

Teach pt/cg in monitoring of blood pressure, pulse, weight and SPO2 with own equipment for discharge and long term cardiac management.

Readmission Risks/Rehab Potential/Discharge Plans

(M1033) ED/Hospital Readmission Risks

Skilled Nursing (6/27/2025)

1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
3 - Multiple hospitalizations (2 or more) in the past 6 months
4 - Multiple emergency department visits (2 or more) in the past 6 months
5 - Decline in mental, emotional, or behavioral status in the past 3 months
6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
7 - Currently taking 5 or more medications
8 - Currently reports exhaustion
9 - Other risk(s) not listed in 1 - 8

Rehabilitation Potential

Skilled Nursing (6/27/2025)

Fair for stated goals.

Discharge Plans

Skilled Nursing (6/27/2025)

Pt to be discharged once goals are met, services are no longer needed and/or pt is no longer homebound.

Advance Care Planning

Code Status	Capacity to Make Own Care Decisions	Health Care Proxy
Prior	Full capacity	Received 6/18/2025

Face to Face Details

Attestation Statement

—

Provider's Signature and Date Signed

Signed by Thomas J Doyle, MD on 6/10/2025

Physician or Allowed Practitioner Certification

I certify/recertify that the above stated patient is homebound and that upon completion of the/this FTF encounter completed on 6/10/25, has a need/continued need for intermittent skilled nursing, physical therapy and/or speech or occupational therapy services in their home for their current diagnosis as outlined in their initial plan of care. These services will continue to be monitored by myself or another physician who will periodically review and update the plan of care as required.

Participants as of 7/1/2025

Name	Type	Comments	Contact Info

Plan of Care (1106391) (continued) Submitted

Robert J Caldas, DO	M0018 Provider	531 FAUNCE CORNER RD HAWTHORN MEDICAL ASSOC. NORTH DARTMOUTH MA 02747 #508-996-3991
Signature pending		
Tiffany E Larose, RN	Case Manager, Skilled Nursing	No address on file

Plan of Care Order Detail: 6/12/2025 - SN - OASIS Start of Care

Provider Details

Authorizing Provider	Last Event	Address
Robert J Caldas, DO	Submit	531 FAUNCE CORNER RD HAWTHORN MEDICAL ASSOC. NORTH DARTMOUTH MA 02747

Entered By

Ericka Powers at 6/30/2025 9:06 AM

Order Date

6/30/2025 9:06 AM

Provider Comments

Provider Signature for Robert J Caldas, DO

Signature: Electronically Signed by Dr. Caldas, Robert J. on 07/11/2025 Date:_____

Order ID for Loureiro,Robert P

1106391