Martinho, Eugenia
99 year old Female

MRN: **2704239**
Date of Birth: **4/1/1926**

Agency Information

Southcoast Visiting Nurse Association Inc.
200 Mill Road
Fairhaven, MA 02719-5252
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Plan of Care (1108757) Submitted

Hospice Plan of Care Recertification 7/7/25

Plan ID: 311373

Effective from: 7/7/2025 Effective to: 9/4/2025

Participants as of Finalize on 7/9/2025

Name	Type	Comments	Contact Info
Jordan C. Gularek, DO	Attending Provider		508-996-3991
Michelle M Boudreau, RN	Case Manager		
Sharon J Furtado, LSW	Medical Social Work		
Lori Howes	Clergy		
Shantel E Frye, LPN	Skilled Nursing		
Mark Shparber, MD	Hospice Medical Director		508-973-7888
Lianna G Tibbetts, RN	Skilled Nursing		

Plan of Care Notes

Case Manager note by Michelle M Boudreau, RN Last edited by Michelle M Boudreau, RN on 6/30/2025 3:08 PM EDT

This is the 5th hospice benefit period for Eugenia Martinho a 99 year old patient of Dr. Gularek with primary hospice diagnosis of Senile degeneration of the brain.
Related Comorbidities: Anxiety, depression, HTN, migraine headaches, TIA, pulmonary embolus (on Eliquis), frequent falls, diastolic dysfunction
Code Status: DNR
MOLST: In chart
POC includes:
•SN: 1x/week
•MSW: 1-2x/mo.
•Spiritual Care: 1-2x/mo.
•HHA: 3x/week
•Volunteer: N/A
Pain is a 0 on the PAINAD scale
PPS:
On admission/last recert: 40%
Now: 40%
NYHA (If applicable)
On admission/last recert:
Now:
FAST (If applicable)
On admission/last recert: 4/30/25- 7d
Now: 6/30/25 7d
Weight:
Last recert: : 4/30/25-119.6lbs
Now: 6/30/25-117lbs

MAC:
Last recert: 4/30/25-RUA-20.5cm
Now: 6/30/25- RUA-20cm
ADLs/Functional Assessment:
On admission/last recert: Fully dependent for all care and needs assistance with feeds now d/t increased tone to bilat UE
Now: Fully dependent for all care and is a 1:1 feed now
Intake and appetite
On admission/last recert: Very poor
Now: Very poor
Medication Changes and Impact: Colace and Miralax discontiued and Dulcolax supp. to be given every other day now.
Medication Reconciliation completed: 6/30/25
Bowel regimen: Senna BID daily with Laculose daily and Dulcolax supp. every other day and daily prn, and Fleet prn
Braden score: 11
DME: Broda chair
99 y.o.female with terminal Dx of SDB eligible to enter next benefit period as evidenced by a continuous weight loss with another 2lb loss in the past 60days as well as a 0.5cm decrease in MAC. Patient is now sleeping app.12-14hrs/day compared to 10-12hrs at last recert. She is unable to shift any weight at all and continues with loss of trunk controll needing to be positioned to maintain from falling to the side. Patient continues with chronic constipation that is no longer being managed with the scheduled bowel meds that included Senna, Colace, Lactulose and Miralax and was needing supp. and Fleets frequently. This RNCM discontinued the Miralax and Colace and added Dulcolax supp. to be given every other day now and will monitor for effect and change POC prn to manage symptoms. Patient is often refusing daily meds just wanting to be left alone and sleep and also will refuse food and drink on those days.
Progress toward patient/family goals: Patient is being kept comfortable without pain and has remained safe despite a continued decline in mobility
Hospice Attending Dr. Gularek, patient/decision maker and IDT attendees aware of hospice recertification and in agreement with POC.
Patient/caregivers aware to call SCVNA with any questions, concerns or changes in condition.

Diagnoses as of 7/9/2025

Diagnoses	ICD-10-CM	ICD-9-CM	Hospice Related
(P) Senile degeneration of brain	G31.1	331.2	Related
Dementia (HCC)	F03.90	294.20	Related
Weight loss	R63.4	783.21	Related
Constipation	K59.00	564.00	Related
PE (pulmonary thromboembolism) (HCC)	I26.99	415.19	Unrelated
HTN (hypertension)	I10	401.9	Unrelated
TIA (transient ischemic attack)	G45.9	435.9	Unrelated
Diastolic dysfunction	I51.89	429.9	Unrelated
Migraine	G43.909	346.90	Unrelated
Anxiety and depression	F41.9, F32.A	300.00, 311	Unrelated

Allergies as of 7/9/2025

Allergen	Reactions	Severity	Type	Noted	Comments
Azithromycin	—	—	—	10/10/2015	—

Medications

Prescriptions and Patient-Reported

Name	Dispense	Refills	Start Date	End Date	Hospice Coverage
acetaminophen (TYLENOL) 325 MG tablet	—	—	3/11/2025	—	Covered

Sig: Take 650 mg by mouth every 8 (eight) hours as needed for mild pain (1-3). Route: Oral					
apixaban (ELIQUIS) 5 MG tablet Sig: Take 5 mg by mouth 2 (two) times a day. Route: Oral Not Covered Reason: a. Not related to hospice diagnosis	—	—	8/17/2021	—	Not Covered
bisacodyl (DULCOLAX) 10 MG suppository Sig: Insert 10 mg into the rectum every other day. Route: Rectal	—	—	6/30/2025	—	Covered
bisacodyl 10 MG suppository Sig: Insert 10 mg into the rectum daily as needed for constipation. Route: Rectal	—	—	9/14/2019	—	Covered
calcium carbonate (TUMS) 500 MG chewable tablet Sig: Chew 1 tablet every 4 (four) hours as needed for indigestion or heartburn Route: Oral Not Covered Reason: a. Not related to hospice diagnosis	—	—	10/10/2015	—	Not Covered
citalopram 20 MG tablet Sig: Take 20 mg by mouth daily. Route: Oral	—	—	11/8/2021	—	Covered
hyoscyamine sulfate 0.125 MG tablet Sig: Take 0.125 mg by mouth every 4 (four) hours as needed (Secretions). Route: Oral	—	—	7/22/2024	—	Covered
lactulose 10 g/15 mL oral solution Sig: Take 10 g by mouth daily. Route: Oral	—	—	5/7/2025	—	Covered
LORazepam 2 mg/mL oral solution concentrate Sig: Take 0.5 mg by mouth daily. in evenin Route: Oral	—	—	3/25/2025	—	Covered
magnesium hydroxide (MILK OF MAGNESIA) 400 mg/5 mL oral suspension Sig: Take 30 mL by mouth daily as needed for constipation. Route: Oral	—	—	9/14/2019	—	Covered
senna (SENOKOT) 8.6 MG tablet Sig: Take 2 tablets by mouth 2 (two) times a day. Route: Oral	—	—	7/22/2024	—	Covered
sodium phosphate (FLEET SALINE ADULT) enema Sig: Insert 1 enema into the rectum daily as needed for constipation. Route: Rectal	—	—	4/24/2025	—	Covered
traMADol 25 MG tablet Sig: Take 25 mg by mouth 2 (two) times a day. Route: Oral	—	—	3/11/2025	—	Covered

Durable Medical Equipment as of 7/9/2025

Name	Start Date	End Date	Hospice Coverage	Not Covered Reason	Comments
Hospital bed	9/10/2024	—	Covered	—	—
Other (specify)	9/10/2024	—	Covered	—	OTB table
Manual wheelchair	9/10/2024	—	Not Covered	Equipment owned by patient or friend.	—
Other (specify)	9/12/2024	—	Covered	—	Broda chair

Planned Visits

Clergy

Visits	Dates
2 to 4 visits as needed Comments: spirtual support	7/7/2025 to 9/4/2025
1 to 2 visits every 4 weeks for 9 weeks	7/7/2025 to 9/4/2025

Home Health Aide

Visits	Dates
3 visits every 6 days for 6 days	7/7/2025 to 7/12/2025
3 visits every week for 7 weeks	7/13/2025 to 8/30/2025
3 visits every 5 days for 5 days	8/31/2025 to 9/4/2025

Medical Social Work

Visits	Dates
1 to 2 visits every 30 days for 60 days Comments: Psychosocial/EOL support	7/7/2025 to 9/4/2025
1 to 4 visits as needed Comments: As needed for EOL support	7/7/2025 to 9/4/2025

Skilled Nursing

Visits	Dates
1 visit every 6 days for 6 days	7/7/2025 to 7/12/2025
1 to 5 visits as needed Comments: for symptom management	7/7/2025 to 9/4/2025
1 visit every week for 7 weeks	7/13/2025 to 8/30/2025
1 visit every 5 days for 5 days	8/31/2025 to 9/4/2025

Problems

All Disciplines

Problem: Fall Prevention

All Disciplines Starting: 9/10/2024
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.

All Disciplines Starting: 9/10/2024
Most recent outcome: Progressing
SNF and Hospice staff will pactice safety measures with transferring patient via hoyer lift through 9/4/25

Intervention: Assess and Instruct on Appropriate Use of Devices/Equipment

All Disciplines Starting: 9/10/2024 Frequency: Each Visit
wheelchair, including locking the wheels
hospital bed, including locking the wheels
supervision

Intervention: Assess and Instruct on Physiological Fall Risk Factors and Prevention

All Disciplines Starting: 9/10/2024 Frequency: Each Visit
dyspnea
anxiety
pain
breathing techniques
relaxation techniques
stand/wait/walk
do not rush to step

Intervention: Report Falls to HCP

All Disciplines Starting: 9/10/2024 Frequency: Each Visit
reported by patient
observed by staff

Problem: Infection Prevention/Precautions

All Disciplines Starting: 9/10/2024
Infection prevention/Precautions

Goal: Understanding universal/standard precautions and proper handling/disposal of infectious materials. Patient/caregiver will be protected from exposure by maintaining universal/standard precautions in the home.

All Disciplines Starting: 9/10/2024
Most recent outcome: Progressing
Establish infection control measures in the SNF to reduce risk of infection and maintain universal/standard precautions by 9/4/25.

Intervention: Assess Risk For Infection

All Disciplines Starting: 9/10/2024 Frequency: Each Visit
Respiratory compromise
Integumentary compromise

Immune system compromise
Long term hospitalization or rehab stay in past year

Intervention: Instruct
All Disciplines Starting: 9/10/2024 Resolved: 2/27/2025
Frequency: Each Visit
Universal/Standard Precautions.
Frequent and proper handwashing.
Disinfecting of contaminated items - including devices, equipment and surfaces.

Clergy

Problem: Spiritual Needs
Clergy Starting: 9/12/2024
Spiritual Plan

Goal: The spiritual needs of patients, caregivers and significant others will be supported.
Clergy Starting: 9/12/2024
The spiritual needs of the patient and family will be supported by providing compassionate listening and traditional/spontaneous prayer through 9/12/25.

Intervention: Contact Clergy of Faith Community
Clergy Starting: 9/12/2024 Frequency: Each Visit

Intervention: Encourage Verbalization
Clergy Starting: 9/12/2024 Frequency: Each Visit
Of feelings and communication of life story

Intervention: Facilitate Conversations about Spiritual Experience
Clergy Starting: 9/12/2024 Frequency: Each Visit
Including issues of suffering, grief, fears, leave taking, reconcilliation, forgiveness and issues of eternity

Intervention: Give Time, Actively Listen
Clergy Starting: 9/12/2024 Frequency: Each Visit

Intervention: Provide Spiritual Support
Clergy Starting: 9/12/2024 Frequency: Each Visit
to pt, caregivers, family and supportive friend(s)

HHA

Problem: Home Health Aide
HHA Starting: 9/10/2024
Alteration in ADLs/IADLs

Goal: Provide HHA services which are reasonable and necessary with patient/caregiver verbalizing satisfaction with services.
HHA Starting: 9/10/2024
Most recent outcome: Progressing 75%
HHA will provide safe and appropriate care in maintaining patient hygiene and Patient/Primary Caregiver will verbalize satisfaction with HHA by 9/4/25.

Intervention: Assist With Bathing
HHA Starting: 9/10/2024 Frequency: Each Visit
tub/shower

Intervention: Assist With Skin Care
HHA Starting: 9/10/2024 Frequency: Each Visit
apply moisture barrier cream to coccyx
pressure ulcer prevention/repositioning
instruct in pressure ulcer prevention - change position, remind pt, family and caregivers of importance of repositioning

Intervention: Hospice Care
HHA Starting: 9/10/2024 Frequency: Each Visit
provide companionship
provide caregiver respite
provide light housekeeping

provide vigil support

Intervention: Other
HHA Starting: 11/7/2024 Frequency: Each Visit
Please weigh patient monthly starting 11/7/24

Intervention: Place Items Within Patient's Reach
HHA Starting: 9/10/2024 Frequency: Each Visit
such as phone, beverage, snack, commode

Intervention: Report Skin Redness/Open Areas to HCP
HHA Starting: 9/10/2024 Frequency: Each Visit

MSW

Problem: Altered mental/emotional status
MSW Starting: 9/11/2024
Through 7/6/2025

Goal: Patient verbalizes emotions, feelings, thoughts and concerns regarding end-of-life care and during care.
MSW Starting: 9/11/2024
Through 9/4/2025

Intervention: Assess Patient/Caregiver/Family Level of Acceptance of Diagnosis/Prognosis.
MSW Starting: 9/11/2024 Frequency: Each Visit

Goal: Patient/caregiver/family feels supported and confident with expectations of end-of-life care and the dying process.
MSW Starting: 9/11/2024
Through 9/4/2025

Intervention: Provide Reassurance, Companionship, and Comfort to Patient/Caregiver/Family.
MSW Starting: 9/11/2024 Frequency: Each Visit

Goal: Patient/caregiver/family verbalize emotions, feelings, thoughts and concerns to decrease and/or resolve stress and increase positive coping during care.
MSW Starting: 9/11/2024
Through 9/4/2025

Intervention: Assess/Monitor Patient/Caregiver/Family's Coping/Emotional Status
MSW Starting: 9/11/2024 Frequency: Each Visit

SN

Problem: Alzheimers/Dementia
SN Starting: 9/10/2024
Alteration in Neuro Status- Alzheimers, Dementia

Goal: Caregiver will verbalize and demonstrate effective care giving and reporting of appropriate symptoms to MD including but not limited to changes in nutrition, hydration, skin integrity, dysphagia, medication, GI/GU and psychosocial issues.
SN Starting: 9/10/2024
Most recent outcome: Progressing
SNF will verbalize symptoms to be reported to MD including issues with nutrition, hydration, skin integrity, dysphagia, medications, GI/GU & psychosocial through 9/4/25

Intervention: Assess Caregiver
SN Starting: 9/10/2024 Resolved: 12/4/2024
Frequency: Each Visit
coping

Intervention: Assess Patient For
SN Starting: 9/10/2024 Frequency: Each Visit
effectiveness of medications
mood and affect
reality and orientation
psychosis

increased/decreased sleep
energy
Poor appetite with supplements to provide nutritional support

Intervention: Patient/Caregiver Instruction

SN Starting: 9/10/2024 Frequency: Each Visit
Symptom management techniques
Disease process

Problem: Anticoagulation Management

SN Starting: 9/10/2024
Anticoagulation Management

Goal: Patient/caregiver will verbalize and demonstrate knowledge of anticoagulation therapy including dietary restrictions, signs/symptoms of bleeding, steps to take with bleeding, individualized therapeutic range and referral to lab for ongoing services.

SN Starting: 9/10/2024
Most recent outcome: Progressing
SNF demonstrate knowledge of anticoagulation therapy such as dietary restrictions, signs and symptoms of bleeding, and steps to take with signs of bleeding by 9/4/25.

Intervention: Instruct on

SN Starting: 9/10/2024 Frequency: Each Visit
Medication and food interactions including aspirin, NSAID, herbal remedies and foods that effect INR
Anticoagulation therapy related precautions, side effects and adverse effects

Problem: Cardiopulmonary General

SN Starting: 9/10/2024
Alteration in Cardiopulmonary status

Goal: Consistent assessment of general cardiopulmonary function with appropriate modifications to treatment as needed.

SN Starting: 9/10/2024
Most recent outcome: Progressing
SNF will verbalize understanding of disease maintenance and hospitalization avoidance and will demonstrate appropriate steps to take with cardiopulmonary exacerbation by 9/4/25.

Intervention: ASSESS VS

SN Starting: 9/10/2024 Frequency: Each Visit
Apical Heart Rate: report pulse of >105 or <55 to HCP
Blood Pressure: report B/P >160/95 or < 90/48 to HCP
SPO2 : on room air and report SPO2 < 90 to HCP
Temperature: patient or SN assess every visit, teach appropriate method to obtain/record temp and report temp > 100.5 to HCP
Respiratory Rate: report Respiratory rate of 28 to HCP

Intervention: Assess and Instruct on Respiratory Status Including Lung Sounds and Breathing Pattern

SN Starting: 9/10/2024 Frequency: Each Visit

Intervention: Assess and Instruct on Self-Management of Respiratory Symptoms

SN Starting: 9/10/2024 Frequency: Each Visit
deep breathe and cough
management of dyspnea
signs and symptoms to report to HCP

Problem: Constipation

SN Starting: 9/10/2024
Alteration in GI status- Constipation

Goal: Patient/Caregiver will verbalize and demonstrate the ability of managing the s/s of constipation, knowledge of dietary measures in improving bowel function and s/s to report to the HCP.

SN Starting: 9/10/2024
Most recent outcome: Progressing
SNF will improve bowel function with the use of laxatives, suppositories and enemas by 9/4/25.

Intervention: Assess and Instruct

SN Starting: 9/10/2024 Frequency: Each Visit

S/S of constipation - Bloating, abdominal distention, nausea, pain, agitation, confusion, restlessness.
Bowel pattern and individualized bowel regimen/management strategies.
Diet to improve bowel function - Foods with dietary fiber or other sources of fiber.
Complications - From long term use of laxatives, suppositories and enemas; frequent GI distress; N/V; long term alteration in GI motility
Stool softeners
Enema administration
Suppository administration
S/S to report to HCP

Problem: End of Life Care

SN Starting: 9/10/2024

End of Life Care

Goal: Provide ongoing caregiver support/education with caregivers demonstrating appropriate care of the dying patient with well managed symptoms and a comfortable death process.

SN Starting: 9/10/2024

Most recent outcome: Progressing

Pt will have a comfortable death with symptoms well managed and caregivers will be supported and demonstrate appropriate care of the dying patient by 9/4/25.

Intervention: Assess Elimination Needs

SN Starting: 9/10/2024 Frequency: Each Visit

need for a Foley catheter
foley catheter
insertion of Foley catheter - French # 16 with a 5 ml balloon. Irrigate catheter PRN with 30 milliliters of sterile water for leakage, blockage or discomfort. Change foley catheter every 4-6 weeks and PRN (prn for leakage, blockage, discomfort and other complications).
enema
bowel assessment
bowel status - pattern, constipation, diarrhea, discomfort
urinary assessment
continence
retention
comfort

Intervention: Assess Physical Symptoms

SN Starting: 9/10/2024 Frequency: Each Visit

Barriers to maintaining intact skin
Mucus membranes for dryness
Need for oxygen
Alteration in intake - ways to keep patient from feeling overwhelmed regarding portion size, high fat high calorie foods as tolerated, easy to chew/spoon foods when approp riate

Intervention: Assess Psychosocial Status

SN Starting: 9/10/2024 Frequency: Each Visit

coping
anxiety

Intervention: Comfort Kit Instruction

SN Starting: 9/10/2024 Frequency: Each Visit

including storage, medications, use and to call hospice prior to opening

Intervention: Conversion of Medication Routes

SN Starting: 9/10/2024 Frequency: Each Visit

from oral, sublingual, G-tube, J-tube, NG tube, rectal, vaginal, topical, nasal spray, suppository or gel as changes in the patient's condition warrant.

Intervention: Instruct in End of Life Process

SN Starting: 9/10/2024 Frequency: Each Visit

controlled drugs - including safe use, signs and sx to report, and proper disposal of medications

medication administration - Including administering via alternate routes when required
signs of approaching death - including steps to take to ensure pt c omfort and when to contact hospice
natural hydration methods
possible complications with IV hydration - including risk for fluid volume overload (as patient's body is going through natural dehydration with preparing for death), need for IV access, decr ease comfort with use of IV and equipment, higher risk for infection
provide and instruct use of assistive equipment
n/v, distention, heartburn, gas

Intervention: Oxygen Therapy

SN Starting: 9/10/2024 Frequency: Each Visit
oxygen @ 1-4 liters/minute continuous or intermittent via nasal cannula for mild respiratory distress or discomfort with breathing

Problem: General Skin / Integumentary

SN Starting: 9/10/2024
Alteration in Integumentary status (actual and/or risk for)

Goal: Free from integumentary complications; able to demonstrate interventions/dietary measures to promote healthy skin.

SN Starting: 9/10/2024
Most recent outcome: Progressing
SNF and hospice will demonstrate pressure relief measures, repositioning, need to keep skin clean and dry, dietary measures to promote healthy skin and rationale for interventions and pt will be free from integumentary complications by 9/4/25

Intervention: Assess and Instruct on Risk of and on Methods to Prevent Skin Breakdown

SN Starting: 9/10/2024 Frequency: Each Visit
Pressure relief techniques
Pressure reduction DME
Patient specific risk factors - decreased mobility, decreased cognition, decreased nutrition, incontinence
Moisture barrier

Problem: Hospice Collaborative Care Plan

SN Starting: 9/10/2024
Hospice Collaborative Plan of Care

Goal: Provide collaborative care.

SN Starting: 9/10/2024
Most recent outcome: Progressing
Hospice team and Alden Court Nursing Care to provide collaborative care for patient through EOL by 9/4/25.

Intervention: ADL'S

SN Starting: 9/10/2024 Frequency: Each Visit
Bathing: Bathing assistance provided by SNF and SCVNA. Personal care items kept in pt's rm.

Dressing: Patient dependent with upper body dressing and dependent with lower body dressing. Clothes kept in pt's rm.

Feeding/Eating: Patient's diet is puree Meal preparation by SNF. Patient prefers to eat in dining area.

Routine weight checks: do not weigh patient.

Intervention: Disciplines

SN Starting: 9/10/2024 Frequency: Each Visit
Current Hospice Disciplines:

Skilled Nursing
MSW
Chaplain

Aide

Intervention: Elimination

SN Starting: 9/10/2024 Frequency: Each Visit

Patient is urinary incontinent and bowel incontinent. Incontinence products supplied by facility. Toilet patient every 8 hours.

Intervention: Evaluate Patient for

SN Starting: 9/10/2024 Frequency: Each Visit

Changes in mental status, non-verbal s/sx of pain, s/sx of infection, constipation, skin break down

Intervention: Mobility

SN Starting: 9/10/2024 Frequency: Each Visit

Patient's ambulation status: non-ambulatory and uses assistive device(s) wheelchair.

Intervention: POC

SN Starting: 9/10/2024 Frequency: Each Visit

Collaborative POC between SC VNA and Alden Court Nursing Care is located in patient's EMR and white hospice binder.

Intervention: Safety

SN Starting: 9/10/2024 Frequency: Each Visit

Safety checks every 1 hour by SNF staff. Safety precautions:
Aspiration precautions.
Bleeding precautions.
Fall precautions.
Standard/universal precautions.

Intervention: Symptom Management and Facility Education on Condition Change Notification

SN Starting: 9/10/2024 Frequency: Each Visit

Instruct facility staff to call Hospice regarding changes in condition, new symptom management orders and/or need for modifications to treatment plan.
Symptom management medications ordered by HSPC attending and delivered by mail delivery pharmacy.

Intervention: Transfer

SN Starting: 9/10/2024 Frequency: Each Visit

Patient's transfer status:
2 assist

Problem: Nutritional Concerns

SN Starting: 9/10/2024

Alt in Nutrition/Diet

Goal: Patient/caregiver will verbalize understanding of diet, including adequate caloric intake, rationale and health benefits of maintaining a normal BMI.

SN Starting: 9/10/2024

Most recent outcome: Progressing

Wt. loss will be minimized with adequate caloric intake and pt will tolerate least restrictive diet with no s/s of aspiration by 9/4/25.

Intervention: Assess for dysphagia

SN Starting: 9/10/2024 Frequency: Each Visit

Intervention: Instruct in dysphagia management

SN Starting: 9/10/2024 Frequency: Each Visit

Problem: Pain

SN Starting: 9/10/2024

Alteration in comfort- Pain

Goal: Achieve acceptable levels of pain, independence with strategies for breakthrough pain and symptoms to report to HCP.

SN Starting: 9/10/2024

Most recent outcome: Progressing

Patient will remain free of pain with current regimen or POC will be changed to maintain comfort through 9/4/25

Intervention: Assess Effectiveness of Pain Medications
SN Starting: 9/10/2024 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
SN Starting: 9/10/2024 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, faces scale, PAINAD

Intervention: Instruct in Pain Management Strategies
SN Starting: 9/10/2024 Frequency: Each Visit
Non-pharmacological strategies, such as rest to achieve acceptable level of pain
Pain medication schedule and dose, including around the clock dosing as prescribed
Exacerbation prevention, such as pre-medication, and dose titration within prescribed ra nge
Alternate strategies as with nonverbal patients and cognitively impaired patients

Intervention: Instruct in Pain Medication and Strategies to Avoid Bowel Complications
SN Starting: 9/10/2024 Frequency: Each Visit

Episode Summary as of 7/9/2025

Election Date	Effective Date	Code Status	Code Status Comments	Triage Code	Place of Service
9/10/2024	9/10/2024	DNR	—	High risk	389 Alden Road Fairhaven MA 02719-4451

Benefit Periods as of 7/9/2025

#	Start Date	End Date	Verbal CTI Date	Certifying Hospice Physician	Attending Physician
1	9/10/2024	12/8/2024	9/10/2024	Sophia Rizk, MD	Jordan C. Gularek, DO
2	12/9/2024	3/8/2025	12/4/2024	Sophia Rizk, MD	Jordan C. Gularek, DO
3	3/9/2025	5/7/2025	2/27/2025	Mark Shparber, MD	Jordan C. Gularek, DO
4	5/8/2025	7/6/2025	4/30/2025	Mark Shparber, MD	Jordan C. Gularek, DO
5	7/7/2025	9/4/2025	6/30/2025	Mark Shparber, MD	Jordan C. Gularek, DO

Participants as of 7/10/2025

Name	Type	Comments	Contact Info
Jordan C. Gularek, DO Signature pending	Attending Provider		508-996-3991
Michelle M Boudreau, RN	Case Manager		
Sharon J Furtado, LSW	Medical Social Work		
Lori Howes	Clergy		
Shantel E Frye, LPN	Skilled Nursing		
Mark Shparber, MD	Hospice Medical Director		508-973-7888
Lianna G Tibbetts, RN	Skilled Nursing		

Plan of Care Order Detail

Provider Details

Authorizing Provider	Last Event	Reviewer	Address
Jordan C. Gularek, DO	Submit	Lianna G Tibbetts, RN	535 FAUNCE CORNER RD NORTH DARTMOUTH MA

Plan of Care Order Detail (continued)

02747-1242

Entered By

Lianna G Tibbetts, RN at 7/9/2025 11:48 AM

Order Date

7/9/2025 11:48 AM

Provider Comments

Provider Signature for Jordan C. Gularek, DO

Signature:_____ Date:_____

Order ID for Martinho,Eugenia

1108757