

Harrison, Delphina T
84 year old Female

MRN: 2556271
Date of Birth: 10/30/1940

Agency Information

Southcoast Visiting Nurse Association Inc.
200 Mill Road
Fairhaven, MA 02719-5252
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Plan of Care (1098335)

Submitted

Hospice Plan of Care Recertification 5/30/25

Plan ID: 305157

Effective from: 5/30/2025 Effective to: 7/28/2025

Participants as of Finalize on 6/3/2025

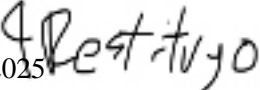
Name	Type	Comments	Contact Info
Irving R. Restituyo, MD	Attending Provider		508-991-9188
Jennifer Cantalupo, RN	Case Manager, Skilled Nursing		
Susan Connery	Clergy		
Erica Ortell, LICSW	Medical Social Work		
Mark Shparber, MD	Hospice Medical Director		508-973-7888
Lianna G Tibbetts, RN	Skilled Nursing		

Plan of Care Notes

Skilled Nursing note by Jennifer Cantalupo, RN Last edited by Jennifer Cantalupo, RN on 5/27/2025 5:44 PM EDT

This is the 4th hospice benefit period for this 84 year old patient of Dr. Restituyo with primary hospice diagnosis of severe protein calorie malnutrition.
Related Comorbidities: Lung cancer, Heart failure, Diverticulitis with abscess, falls, Anxiety, Depression, Severe aortic stenosis, Panlobular emphysema, and Colovesical fistula
Code Status/ MOLST: DNR
POC includes:
• SN: 1X weekly
• MSW 1-2/month and PRN
• Spiritual Care 1-2/month and PRN
• HHA 3XWeek
Pain is a 0/10 on the numeric numeric scale
PPS: 30%
NYHA: III
FAST
On last recert: 7a
MAC:
On last recert: 23 cm RUE 3/19/25
Now: 21.5 cm RUE 05/21/25
ADLs/Functional Assessment: bedbound; unable to transfer as pt BP drops too rapidly with CMS
Intake and appetite poor
Medication Changes and Impact: DC tramadol due to CMS; started morphine 2.5 mg every 3 hours PRN with good results; Started ativan 0.5 mg QHS with good results; pt reports sleeping better and less anxiety at bedtime
Medication Reconciliation completed: yes
Bowel regimen: MOM; dulcosate PRN

Physician: Dr. Restituyo, Irving R.

Signature: 
Date: 6/9/2025

Electronically signed by Dr. Restituyo, Irving R. on 6/9/2025

Plan of Care (1098335) (continued)

Submitted

Braden score: 10

DME: hospital bed; low loss air mattress

Patient remains eligible to receive hospice services due to (describe physical/functional/cognitive decline):
over the last 60 days pt has remained bedbound due to severe orthostatic hypotention and rapid heart rate;
pt appetite continues to be poor and inconsistent; pt has been refusing solid meals for over 30 days and has
relied on ensure shakes approximately 1-2 per day; SCHAH provides pt's ensure shakes; pt is incontinent of
B&B; MAC decreased by 1.5 cm since last recert; new onset mental status change noted at recertification;
pt continues with difficulty maintaining linear thought; pt sleeps more and more during the day approximately
18-20 hrs per day; previously sleeping less than 16-18 hours at last recert; continuing to monitor for further
decline

Progress toward patient/family goals: progressing toward goal of passing peacefully at Brandonwoods NB
Hospice Attending Dr. Restituyo, 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 6/3/2025

Diagnoses	ICD-10-CM	ICD-9-CM	Hospice Related
(P) Severe protein-calorie malnutrition	E43	262	Related
Cachexia	R64	799.4	Related
Poor appetite	R63.0	783.0	Related
Weight loss	R63.4	783.21	Related
Weakness	R53.1	780.79	Related
Fatigue	R53.83	780.79	Related
HTN (hypertension)	I10	401.9	Unrelated
Chronic heart failure with preserved ejection fraction (HFpEF) (HCC)	I50.32	428.9	Unrelated
Severe aortic stenosis	I35.0	424.1	Unrelated
Hypercholesterolemia	E78.00	272.0	Unrelated
Panlobular emphysema (HCC)	J43.1	492.8	Unrelated
Gastroesophageal reflux disease without esophagitis	K21.9	530.81	Unrelated
Anxiety and depression	F41.9, F32.A	300.00, 311	Unrelated

Allergies as of 6/3/2025

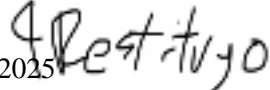
Allergen	Reactions	Severity	Type	Noted	Comments
Penicillins	Swelling	Medium	—	1/20/2017	Tolerated vantin Dr Qu 5/2024 and tolerated Cefepime and Ceftriaxone 2023 and 2024

Medications

Prescriptions and Patient-Reported

Name	Dispense	Refills	Start Date	End Date	Hospice Coverage
† acetaminophen 325 MG tablet Sig: Take 650 mg by mouth every 4 (four) hours as needed for fever or mild pain (1-3). Route: Oral	—	—	10/2/2024	—	Covered
bisacodyl 10 MG suppository Sig: Insert 10 mg into the rectum daily as needed for constipation. Route: Rectal	—	—	10/2/2024	—	Covered
cholecalciferol (VITAMIN D3) 125 mcg (5000 units) capsule Sig: Take 5,000 Units by mouth daily. Route: Oral Not Covered Reason: a. Not related to hospice diagnosis	—	—	10/2/2024	—	Not Covered
digoxin (LANOXIN) 62.5 MCG tablet Sig: Take 0.625 mcg by mouth daily. Route: Oral Not Covered Reason: a. Not related to hospice diagnosis	—	—	10/2/2024	—	Not Covered
docusate sodium 100 MG capsule Sig: Take 100 mg by mouth daily. Route: Oral	—	—	10/7/2024	—	Covered
guaifenesin 200 MG/5ML oral liquid	—	—	10/7/2024	—	Not Covered

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Sig: Take 200 mg by mouth every 4 (four) hours as needed for congestion or cough. Route: Oral					
Not Covered Reason: a. Not related to hospice diagnosis					
* ipratropium-albuterol (DUONEB) 0.5-2.5 mg/3 mL inhalation solution	—	—	10/2/2024	—	Not Covered
Sig: Take 3 mL by nebulization every 6 (six) hours as needed for shortness of breath or wheezing. Route: Nebulization					
Not Covered Reason: a. Not related to hospice diagnosis					
* LORazepam (ATIVAN) 0.5 MG tablet	—	—	1/24/2025	—	Covered
Sig: Take 0.5 mg by mouth at bedtime. Route: Oral					
* LORazepam (ATIVAN) 0.5 MG tablet	—	—	1/24/2025	—	Covered
Sig: Take 0.5 mg by mouth every 6 (six) hours as needed for anxiety. Route: Oral					
magnesium hydroxide (MILK OF MAGNESIA) 400 mg/5 mL oral suspension	—	—	10/2/2024	—	Covered
Sig: Take 30 mL by mouth daily as needed for constipation. Route: Oral					
metoprolol succinate 25 MG extended release tablet	—	—	10/2/2024	—	Not Covered
Sig: Take 12.5 mg by mouth daily. Route: Oral					
Not Covered Reason: a. Not related to hospice diagnosis					
* Multiple Vitamin (ONE-DAILY MULTI VITAMINS) tablet	—	—	2/25/2024	—	Not Covered
Sig: Take 1 tablet by mouth daily. Route: Oral					
Not Covered Reason: a. Not related to hospice diagnosis					
* omeprazole (PriLOSEC) 20 MG delayed release capsule	—	2	6/12/2017	—	Not Covered
Sig: Take 1 capsule (20 mg total) by mouth daily. Route: Oral					
Not Covered Reason: a. Not related to hospice diagnosis					
oxygen therapy (O2)	—	—	10/2/2024	—	Covered
Sig: Inhale 1 L/min as needed (SOB/comfort). Route: Inhalation					
simvastatin (ZOCOR) 40 MG tablet	—	—	11/22/2021	—	Not Covered
Sig: Take 1 tablet (40 mg total) by mouth at bedtime. Route: Oral					
Not Covered Reason: a. Not related to hospice diagnosis					
* sodium phosphates (FLEET) saline enema	—	—	10/2/2024	—	Covered
Sig: Insert 1 enema into the rectum daily as needed for constipation. Route: Rectal					
traMADol 50 MG tablet	—	—	10/2/2024	—	Covered
Sig: Take 50 mg by mouth every 6 (six) hours as needed for moderate pain (4-6) or severe pain (7-10). Route: Oral					

Durable Medical Equipment as of 6/3/2025

Name	Start Date	End Date	Hospice Coverage	Not Covered Reason	Comments
Low air loss mattress	10/2/2024	—	Covered	—	—
Hospital bed	10/2/2024	—	Covered	—	—
Oxygen concentrator	10/2/2024	—	Covered	—	enos

Planned Visits

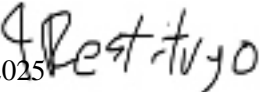
Clergy

Visits	Dates
2 to 4 visits as needed	5/30/2025 to 7/28/2025
Comments: spiritual, grief, social and emotional support for the Pt/Family	
1 to 2 visits every month for 2 months	6/1/2025 to 7/28/2025

Home Health Aide

Visits	Dates
1 visit every day for 1 day	5/30/2025 to 5/30/2025

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5 visits every week for 8 weeks
1 visit every day for 1 day

6/1/2025 to 7/26/2025
7/28/2025 to 7/28/2025

Medical Social Work

Visits

1 to 2 visits every month for 2 months
Comments: psychosocial support to improve coping
1 to 2 visits as needed
Comments: additional family/resources/crisis support

Dates
6/1/2025 to 7/28/2025
6/1/2025 to 7/28/2025

Skilled Nursing

Visits

5 visits as needed
Comments: for changes in health status requiring SN assessment/intervention
1 visit every week for 8 weeks

Dates
5/30/2025 to 7/28/2025
6/1/2025 to 7/26/2025

Problems

All Disciplines

Problem: Fall Prevention

All Disciplines Starting: 10/2/2024
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: 10/2/2024
Most recent outcome: Progressing 25%
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 strategies to prevent falls including modification of environment, through end of cert period 7/28/2025

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

All Disciplines Starting: 10/2/2024 Frequency: Each Visit
hospital bed, including locking the wheels

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

All Disciplines Starting: 10/2/2024 Frequency: Each Visit
dyspnea
anxiety
pain
breathing techniques
relaxation techniques
stand/wait/walk
do not rush to step

Intervention: : Assess/Instruct Regarding Fall Risk Factors and Prevention

All Disciplines Starting: 10/2/2024 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 skid and supportive
non skid, stable stairs
review/removal of all trip hazards such as placement of electrical cords, oxygen tubing, IV tubing, and scatter rugs

Intervention: : Report Falls to HCP

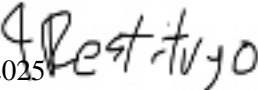
All Disciplines Starting: 10/2/2024 Frequency: Each Visit
observed by staff

Problem: Infection Prevention/Precautions

All Disciplines Starting: 10/2/2024
Infection prevention/Precautions

Goal: Understanding universal/standard precautions and proper handling/disposal of

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infectious materials. Patient/caregiver will be protected from exposure by maintaining universal/standard precautions in the home.

All Disciplines Starting: 10/2/2024

Most recent outcome: Progressing 25%

Establish infection control measures in the home to reduce risk of infection

Maintain contact precautions secondary to scabies outbreak on 3rd floor unit until unit is cleared or 03/20/2025

Pt/caregiver will be protected from exposure and verbalize proper handling/disposal of infectious materials, through end of cert period 7/28/2025

Intervention: : Assess Risk For Infection

All Disciplines Starting: 10/2/2024

Frequency: Each Visit

Respiratory compromise

Integumentary compromise

Intervention: : Instruct

All Disciplines Starting: 10/2/2024

Resolved: 12/30/2024

Frequency: Each Visit

Universal/Standard Precautions.

Frequent and proper handwashing.

Problem: O2 Therapy

All Disciplines Starting: 10/2/2024

Oxygen Therapy

Goal: Patient/caregiver will verbalize and demonstrate understanding of safe O2 use, storage and handling. Patient will also maintain adequate oxygen saturation with all activities.

All Disciplines Starting: 10/2/2024

pt will maintain adequate oxygen saturation without adverse effects and pt will demonstrate appropriate use and care of oxygen equipment, through end of cert period 7/28/2025

Intervention: : Assess and Instruct on Smoking Cessation

All Disciplines Starting: 10/2/2024

Frequency: Each Visit

Intervention: : Instruct Patient/Caregiver on Oxygen Management/Maintenance:

All Disciplines Starting: 10/2/2024

Frequency: Each Visit

tubing and humidifier changes as appropriate

signs and symptoms of complications with oxygen therapy to report to HCP

proper use of mask/cannula and appropriate liter flow

Intervention: : Instruct Patient/Caregiver on Use of Home Oxygen Safety Including:

All Disciplines Starting: 10/2/2024

Frequency: Each Visit

No smoking and posting 'No Smoking' signage in home

No oxygen use within 10-feet of open flames (including fireplaces, wood-burning/gas stoves and candles)

Proper storage of tanks/concentrators in open, well ventilated areas away from heat and direct sunlight

Safe use of tubing

Avoiding application of petroleum based lip products (Blistex, Chapstick, vaseline) to your nose, lips or lower face

Avoiding use of electric razors, hair dryers and heating pads

Avoiding nylon or woolen clothing/blankets which can cause static electricity

Use of humidifier in winter to add moisture to dry air

Intervention: : Oxygen Needs

All Disciplines Starting: 10/2/2024

Frequency: Each Visit

nasal cannula

Problem: Pain

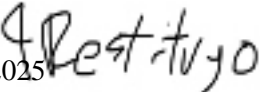
All Disciplines Starting: 10/2/2024

Alteration in comfort- Pain

Goal: Achieve acceptable levels of pain, independence with strategies for breakthrough

pain and symptoms to report to HCP.

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All Disciplines Starting: 10/2/2024

Most recent outcome: Progressing 25%

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, through end of cert period 7/28/2025

Intervention: : Assess Effectiveness of Pain Medications

All Disciplines

Starting: 10/2/2024

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

All Disciplines

Starting: 10/2/2024

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

All Disciplines

Starting: 10/2/2024

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 range

Alternate strategies as with child, nonverbal patients, and cognitively impaired patients

Intervention: : Instruct in Pain Medication and Strategies to Avoid Bowel Complications

All Disciplines

Starting: 10/2/2024

Frequency: Each Visit

Clergy

Problem: Spiritual Needs

Clergy

Spiritual Plan

Starting: 10/3/2024

Goal: The spiritual needs of patients, caregivers and significant others will be supported.

Clergy

Starting: 10/3/2024

Chaplain visits 1-2x a month or as needed through recert period to offer spiritual support through end of life through presence, education and prayer Through 7/28/25

Intervention: : Assist in Spiritual Practices

Clergy

Starting: 10/3/2024

Frequency: Each Visit

Such as prayer and readings

Intervention: : Give Time, Actively Listen

Clergy

Starting: 10/3/2024

Frequency: Each Visit

Intervention: : Provide Grief Support

Clergy

Starting: 10/3/2024

Frequency: Each Visit

Intervention: : Provide Spiritual Support

Clergy

Starting: 10/3/2024

Frequency: Each Visit

to pt, caregivers, family and supportive friend(s)

HHA

Problem: Home Health Aide

HHA

Alteration in ADLs/IADLs

Starting: 10/2/2024

Goal: Provide HHA services which are reasonable and necessary with patient/caregiver

Verbalizing satisfaction with services.

HHA

Starting: 10/2/2024

HHA will provide safe and appropriate care in maintaining patient hygiene

Patient/Primary Caregiver will verbalize satisfaction with HHA, through end of cert period 7/28/2025

Intervention: : Assist With Bathing

HHA

Starting: 10/2/2024

Frequency: Each Visit

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bed/sponge bath

Intervention: : Assist With Dressing

HHA Starting: 10/2/2024 Frequency: Each Visit
Assist with shoes and socks

Intervention: : Assist With Feeding

HHA Starting: 10/2/2024 Frequency: Each Visit
feed patient
follow diet regular

Intervention: : Assist With Grooming

HHA Starting: 10/2/2024 Frequency: Each Visit
hair care
assist with mouth care and oral hygiene swab - teeth, gums, tongue and mouth
nail care - clean/file (DO NOT CUT)
shave with electric shaver for safety each visit or as requested

Intervention: : Assist With Mobility

HHA Starting: 10/2/2024 Frequency: Each Visit
two person assist

Intervention: : Assist With Skin Care

HHA Starting: 10/2/2024 Frequency: Each Visit
apply elbow/heel protection
pressure ulcer prevention/repositioning
instruct in pressure ulcer prevention - change position, remind pt, family and caregivers of importance
of repositioning
skin care lotion

Intervention: : Assist with elimination

HHA Starting: 10/2/2024 Frequency: Each Visit
incontinence care - clean perineal area and buttocks with soap and water, rinse and dry thoroughly
absorbent undergarment (adult diaper)

Intervention: : Hospice Care

HHA Starting: 10/2/2024 Frequency: Each Visit
provide companionship
provide caregiver respite
provide light housekeeping
provide vigil support

Intervention: : Make Bed/Change Linens As Requested

HHA Starting: 10/2/2024 Frequency: Each Visit

Intervention: : Place Items Within Patient's Reach

HHA Starting: 10/2/2024 Frequency: Each Visit
such as phone, beverage, snack, commode

Intervention: : Report Skin Redness/Open Areas to HCP

HHA Starting: 10/2/2024 Frequency: Each Visit

Intervention: : Reposition as Needed

HHA Starting: 10/2/2024 Frequency: Each Visit

MSW

Problem: Altered mental/emotional status

MSW Starting: 10/3/2024
thru 7/28/25

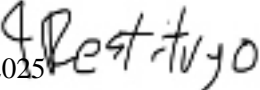
Goal: Patient verbalizes emotions, feelings, thoughts and concerns regarding end-of-life care and during care.

MSW Starting: 10/3/2024
thru 7/28/25

Intervention: : Assess Patient/Caregiver/Family Level of Acceptance of Diagnosis/Prognosis.

MSW Starting: 10/3/2024 Frequency: Each Visit

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⊙ **Goal: Patient/caregiver/family feels supported and confident with expectations of end-of-life care and the dying process.**

MSW Starting: 10/3/2024
thru 7/28/25

Intervention: : Provide Reassurance, Companionship, and Comfort to Patient/Caregiver/Family.

MSW Starting: 10/3/2024 Frequency: Each Visit

⊙ **Goal: Patient/caregiver/family utilizes effective communication to promote positive patient care.**

MSW Starting: 10/3/2024
thru 7/28/25

Intervention: : Instruct Patient/Caregiver/Family on Importance of Positive Communication

MSW Starting: 10/3/2024 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: 10/3/2024
thru 7/28/25

Intervention: : Assess/Monitor Patient/Caregiver/Family's Coping/Emotional Status

MSW Starting: 10/3/2024 Frequency: Each Visit

SN

✂ **Problem: Cardiopulmonary General**

SN Starting: 10/2/2024

Alteration in Cardiopulmonary status

Goal: Consistent assessment of general cardiopulmonary function with appropriate

⊙ **modifications to treatment as needed.**

SN Starting: 10/2/2024

Most recent outcome: Progressing 25%

Pt/caregiver will verbalize understanding of disease maintenance and hospitalization avoidance

Pt/caregiver will demonstrate/verbalize appropriate steps to take with cardiopulmonary exacerbation, through end of cert period 7/28/2025

Intervention: : ASSESS VS

SN Starting: 10/2/2024 Frequency: Each Visit
assess VS and SPO2 PRN

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

SN Starting: 10/2/2024 Frequency: Each Visit

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

SN Starting: 10/2/2024 Frequency: Each Visit

deep breathe and cough
management of dyspnea
signs and symptoms to report to HCP

Intervention: : Skilled Assessment

SN Starting: 10/2/2024 Frequency: Each Visit

activity intolerance
fatigue
energy conservation

✂ **Problem: End of Life Care**

SN Starting: 10/2/2024

End of Life Care

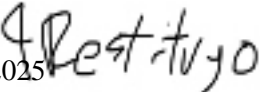
Goal: Provide ongoing caregiver support/education with caregivers demonstrating appropriate care of the dying patient with well managed symptoms and a comfortable death

⊙ **process.**

SN Starting: 10/2/2024

Most recent outcome: Progressing 25%

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Pt will have a comfortable death with symptoms well managed
Caregivers will be supported and demonstrate appropriate care of the dying patient, through end of cert period 7/28/2025

Intervention: : Other

SN

Starting: 10/2/2024

Resolved: 12/27/2024

Frequency: Each Visit

Problem: General Skin / Integumentary

SN

Starting: 10/2/2024

Alteration in Integumentary status (actual and/or risk for)

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

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

SN

Starting: 10/2/2024

Most recent outcome: Progressing 25%

Pt/caregiver will verbalize/demonstrate pressure relief measures, repositioning, need to keep skin clean and dry, dietary measures to promote healthy skin and rationale for interventions

Pt will be free from integumentary complications, through end of cert period 7/28/2025

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

Breakdown

SN

Starting: 10/2/2024

Frequency: Each Visit

Pressure relief techniques

Pressure reduction DME

Patient specific risk factors

Moisture barrier

Problem: Hospice Collaborative Care Plan

SN

Starting: 10/2/2024

Hospice Collaborative Plan of Care

Goal: Provide collaborative care.

SN

Starting: 10/2/2024

Most recent outcome: Progressing 25%

To provide collaborative care for patient's through end of cert period 7/28/2025

Intervention: : POC

SN

Starting: 10/2/2024

Frequency: Each Visit

Collaborative POC between SC VNA and Brandon Woods is located in patient's chart.

Problem: Medication Management and Safety

SN

Starting: 10/2/2024

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.

SN

Starting: 10/2/2024

Most recent outcome: Progressing 25%

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, through end of cert period 7/28/2025

Intervention: : Assess Medications

SN

Starting: 10/2/2024

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

SN

Starting: 10/2/2024

Frequency: Each Visit

Pt/cg will verbalize understanding of:

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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: Nutritional Concerns

SN Starting: 10/3/2024
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: 10/3/2024
Most recent outcome: Progressing 25%

Pt/caregiver will be knowledgeable regarding prescribed diet, including health benefits and rationale.
Wt. loss/gain will be minimized with adequate caloric intake.

Pt will tolerate least restrictive diet with no s/s of aspiration.

Pt will verbalize understanding of healthy BMI and benefits of long term wt. management, through end of cert period 7/28/2025

Intervention: : Assess Patient's Nutritional Status and Ability to Eat/Feed Self

SN Starting: 10/3/2024 Frequency: Each Visit
Oral cavity (assessing for lesions, pain, poor fitting dentures, thrush, missing teeth or dentures)
Altered taste
Eating patterns including the impact of loneliness and depression on appetite

Intervention: : Assess and Instruct on S/S of Dehydration

SN Starting: 10/3/2024 Frequency: Each Visit

Episode Summary as of 6/3/2025

Election Date	Effective Date	Code Status	Code Comments	Triage Code	Place of Service
10/2/2024	10/2/2024	DNR	—	High risk	397 County Street New Bedford MA 02740-4933

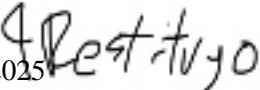
Benefit Periods as of 6/3/2025

#	Start Date	End Date	Verbal CTI Date	Certifying Hospice Physician	Attending Physician
1	10/2/2024	12/30/2024	10/2/2024	Mark Shparber, MD	Irving R. Restituyo, MD
2	12/31/2024	3/30/2025	12/16/2024	Sophia Rizk, MD	Irving R. Restituyo, MD
3	3/31/2025	5/29/2025	3/25/2025	Mark Shparber, MD	Irving R. Restituyo, MD
4	5/30/2025	7/28/2025	5/21/2025	Mark Shparber, MD	Irving R. Restituyo, MD

Participants as of 6/4/2025

Name	Type	Comments	Contact Info
Irving R. Restituyo, MD Signature pending	Attending Provider		508-991-9188
Jennifer Cantalupo, RN	Case Manager, Skilled Nursing		
Susan Connery	Clergy		
Erica Ortell, LICSW	Medical Social Work		
Mark Shparber, MD	Hospice Medical Director		508-973-7888
Lianna G Tibbetts, RN	Skilled Nursing		

Physician: Dr. Restituyo, Irving R.

Signature: 
Date: 6/9/2025

Electronically signed by Dr. Restituyo, Irving R. on 6/9/2025

Provider: Irving R. Restituyo, MD; Patient: Harrison, Delphina T; MRN: 2556271

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Other Order Detail

Provider Details

Authorizing Provider	Last Event	Reviewer	Address
Irving R. Restituyo, MD	Submit	Lianna G Tibbetts, RN	651 ORCHARD STREET NEW BEDFORD MA 02744

Entered By

Lianna G Tibbetts, RN at 6/3/2025 3:22 PM

Order Date

6/3/2025 3:22 PM

Provider Comments

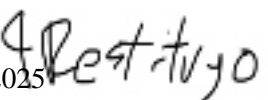
Provider Signature for Irving R. Restituyo, MD

Signature: _____ Date: _____

Order ID for Harrison, Delphina T

1098335

Physician: Dr. Restituyo, Irving R.

Signature: 
Date: 6/9/2025

Electronically signed by Dr. Restituyo, Irving R. on 6/9/2025