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
Ph: 508-973-3200
Fx: 508-973-3417

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

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Signature: IRestituyo
Date: 6/9/2025

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

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 recetrtification; pt continues with difficulty maintaining linear thought; pt sleeps more and more during the day approximately 18-20 hrs per day; previosuly 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	—	—	10/2/2024	—	Covered
Sig: Take 650 mg by mouth every 4 (four) hours as needed for fever or mild pain (1-3). Route: Oral					
bisacodyl 10 MG suppository	—	—	10/2/2024	—	Covered
Sig: Insert 10 mg into the rectum daily as needed for constipation. Route: Rectal					
cholecalciferol (VITAMIN D3) 125 mcg (5000 units) capsule	—	—	10/2/2024	—	Not Covered
Sig: Take 5,000 Units by mouth daily. Route: Oral Not Covered Reason: a. Not related to hospice diagnosis					
digoxin (LANOXIN) 62.5 MCG tablet	—	—	10/2/2024	—	Not Covered
Sig: Take 0.625 mcg by mouth daily. Route: Oral Not Covered Reason: a. Not related to hospice diagnosis					
docusate sodium 100 MG capsule	—	—	10/7/2024	—	Covered
Sig: Take 100 mg by mouth daily. Route: Oral					
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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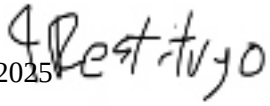
Signature: 

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5 visits every week for 8 weeks	6/1/2025 to 7/26/2025
1 visit every day for 1 day	7/28/2025 to 7/28/2025

Medical Social Work

Visits	Dates
1 to 2 visits every month for 2 months	6/1/2025 to 7/28/2025
Comments: psychosocial support to improve coping	
1 to 2 visits as needed	6/1/2025 to 7/28/2025
Comments: additional family/resources/crisis support	

Skilled Nursing

Visits	Dates
5 visits as needed	5/30/2025 to 7/28/2025
Comments: for changes in health status requiring SN assessment/intervention	
1 visit every week for 8 weeks	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 strategie s 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 p roper handlingdisposal 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/canula 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 s unlight
Safe use of tubing
Avoiding application of petroleum based lip products (Blistex, Chapstik, vaseline) to your nose, lips or lower face
Avoiding use of electric razors, hair dryers and heating pads
Avoiding nylon or woolen clothing/blankets wh ich 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 c omplications 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 Starting: 10/3/2024
Spiritual Plan

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 though 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 Starting: 10/2/2024
Alteration in ADLs/IADLs

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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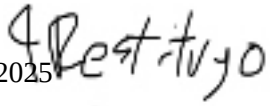
Signature: 

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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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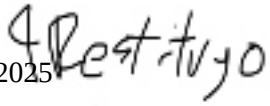
Signature: 

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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.
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
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 u nderstanding 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 Status 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: IRestituyo

Date: 6/9/2025

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

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: IRestituyo

Date: 6/9/2025

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