Houston Neuropsychology Associates, PLLC

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Neuropsychological Evaluation

NAME:	Nilda Bravo de Mata	**GENDER:**	Female
DATE OF BIRTH:	01/27/1952 (74)	**HANDEDNESS:**	Right
DATE OF EXAM:	07/15/2026	**ETHNICITY:**	Hispanic
EDUCATION:	12	**MARITAL STATUS:**	Married
OCCUPATION:	Homemaker	**REFERRED BY:**	M. Roberts-Boyd, APRN

REASON FOR REFERRAL

Ms. Bravo de Mata was referred for evaluation due to suspected cognitive decline. Results will elucidate her current level of cognitive, emotional, and behavioral functioning to inform diagnostic decision-making and treatment planning.

PRESENTING PROBLEMS

Ms. Bravo de Mata presented with complaints of cognitive difficulties that were explicitly noted to have begun or worsened around December 2024. During the clinical interview, the patient denied experiencing problems across any cognitive domains. However, collateral information provided by her husband during the interview and on family rating scales highlighted significant functional and cognitive changes. He reported that while she is able to retain information she watches on television, she frequently forgets conversations, dates, and appointments, and she is sometimes confused regarding the day or time. He also observed a decline in her processing speed and noted that she has difficulty with decision-making abilities. Regarding communication, he reported that while she can generally reply to questions, she rarely initiates conversations. Furthermore, she has become increasingly dependent on him, wishing to be with him at all times, and becomes easily confused when traveling to unfamiliar locations. Her disorientation is severe at times; her husband reported that when returning home, she occasionally does not recognize their house and has had to be forcefully brought inside by family members. In one recent instance, she wandered to a neighbor's house believing it was her own, which resulted in police intervention.

Emotionally and behaviorally, Ms. Bravo de Mata endorsed current feelings of anxiety and a history of significant depressive symptoms. She endorsed experiencing suicidal ideation frequently over the past several months, though she denied having a current active plan. She identified her four-year-old grandson as a strong protective factor that prevents her from acting on these thoughts. Her husband confirmed they plan to discuss her suicidal ideation with her psychiatrist at an upcoming appointment. Results from family rating scales corroborated the presence of depression and anxiety, while also highlighting the presence of agitation, apathy, and impulsivity. Regarding neurovegetative symptoms, she reported fluctuating sleep patterns with frequent nighttime awakenings and stated that she tires quickly. While she reported an increase in her appetite—a symptom corroborated by her husband on rating scales—her husband noted a discrete period in late 2024 where she stopped eating and drinking, resulting in a 16-kilogram weight loss in a single week. This acute decline was initially attributed to depression but subsequently led to a diagnosis of Alzheimer's disease following medical evaluation.

Ms. Bravo de Mata also experiences prominent psychiatric disturbances, which her husband endorsed on rating scales, including frequent visual and auditory hallucinations that began around June 2025. These hallucinations fluctuate but have progressively worsened, though her husband noted they improve when she strictly adheres to her psychiatric medication regimen. Additionally, she experiences severe delusions of misidentification, frequently failing to recognize her husband. She occasionally confuses him for an uncle or cousin, believes he is an impostor trying to deceive her, and suffers from delusions of infidelity, claiming she has seen him with female neighbors. These delusions intensified at the beginning of the current year, and her resulting confusion can persist for days at a time. She also reports traveling and believes she has been to places before, and frequently converses with deceased family members.

Functionally, Ms. Bravo de Mata requires assistance with basic activities of daily living. On rating scales, her husband indicated she requires assistance with dressing, bathing, self-grooming, and personal hygiene. While prior medical records noted improving bowel incontinence following a colon resection, her husband reported on recent scales that she is currently incontinent for both urinary and fecal matter. Her motor movements are remarkably slow, particularly when exiting a vehicle. She has a history of falling within the past year and feels unsteady when standing or walking. Regarding instrumental activities of daily living, family rating scales indicate she requires assistance with shopping, telephone use, driving, and medication management. She never drove in the United States and experiences significant spatial disorientation, no longer knowing how to navigate to familiar locations. Her husband entirely manages her medical appointments and medication administration. While her husband provides medication oversight, he noted she occasionally exhibits non-compliance due to reluctance to take her pills. He also indicated she can no longer manage finances independently. She remains capable of cooking but requires supervision, as she has previously left the stove on; consequently, her husband has assumed the majority of cooking responsibilities.

MEDICAL HISTORY

Conditions: Medical history is significant for hypertension, Type 2 diabetes, hyperlipidemia, Stage IV chronic kidney disease, a history of cerebrovascular accident (CVA), myocardial infarction, brain injury/encephalopathy, arthritis, chronic low back pain, scoliosis, claustrophobia, and a vitamin D deficiency.

While medical records indicate a history of a single right MCA infarction in June 2024 with left hemiparesis, her husband reported being informed she has suffered three strokes. Additionally, while records indicate coronary artery disease status post stents and CABG, her husband explicitly denied a history of stents during the clinical interview.

Surgeries: History of a colon surgery/hemicolectomy in 2021 for diverticulosis, breast nodule removal and size reduction, bladder displacement correction, appendectomy, cholecystectomy, and a nasal/sinus endoscopic surgery with dacryocystorhinostomy.

Imaging: An MRI of the brain without contrast, dated 12/31/2024, was unremarkable. An MRI of the thoracic spine revealed a syrinx at T1. A CT of the head without contrast in January 2025 showed chronic small vessel ischemic change, as well as bilateral frontal and right occipital encephalomalacia, with no acute intracranial process.

Current medications: Aspirin 81 mg, Atorvastatin 20 mg, Memantine HCl 10 mg, Risperidone 1 mg, Sertraline 50 mg, Valsartan 320 mg, and Vitamin D supplementation. She reportedly discontinued Propranolol ER 60 mg the day prior to the evaluation.

Substance use: Ms. Bravo de Mata has never used nicotine or tobacco products, alcohol, or illicit substances.

Family history: Her mother died of liver cancer, and her father died of a heart attack. The health of her siblings is unknown. There is no known family history of dementia.

MENTAL HEALTH HISTORY

Ms. Bravo de Mata reported a longstanding history of anxiety and depression, with symptoms initially emerging around age 25 and fluctuating throughout her life. She developed severe claustrophobia around 1999 or 2000, coinciding with socio-political unrest in Venezuela that resulted in a decade-long geographical separation from her husband. During that period, she received treatment from both a psychiatrist and a psychologist for therapy and medication management. Following her immigration to the United States in 2019, she experienced a gap in psychiatric care until 2024. She is currently established with a psychiatrist, Dr. Gretel Salazar, for medication management, though she is not currently engaged in psychological counseling. Despite ongoing treatment with Sertraline and Risperidone since 2024, she and her husband have not observed significant improvements in her mood symptoms. She endorsed a remote history of suicidal ideation and planning in the early 2000s, though she did not attempt self-harm. She denied any history of psychiatric hospitalizations.

EDUCATIONAL HISTORY

Ms. Bravo de Mata completed 12 years of formal education, obtaining the equivalent of a high school diploma in Venezuela. She denied a history of learning problems or grade retention.

OCCUPATIONAL HISTORY

Ms. Bravo de Mata is currently retired. Her occupational history includes working as a secretary for 13 years and as a flight attendant for five years. Subsequently, she and her husband owned and operated a home-based retail business for approximately five years before she fully transitioned to the role of a homemaker.

SOCIAL HISTORY

Ms. Bravo de Mata was born and raised in Venezuela and immigrated to the United States on November 12, 2019. She has been married to her husband for nearly 50 years, and they share two adult children, a son and a daughter. She currently resides in Magnolia, Texas, living with her husband, their daughter, a son-in-law, and her grandson.

BEHAVIORAL OBSERVATIONS

Ms. Bravo de Mata presented as a well-groomed woman with adequate hygiene. She was alert but partially disoriented during the evaluation; while she could correctly state the day of the week, date, month, and year, she was unable to identify the current time, her street address, the city (stating "TX" instead), or her correct age (reporting that she was 83 years old). The examiner noted that her gait was slow when walking and she exhibited some balance difficulties, though

her gross motor skills were otherwise unremarkable. Vision and hearing appeared adequate for testing purposes. Expressive and receptive language was within normal limits during casual conversation, and her general attention and concentration appeared normal. However, the examiner noted that she required simplified test instructions and occasional reminders to complete the tasks. Her mood was described as pleasant, though she presented with a flat affect. Notably, the examiner documented the presence of active delusions during the session, as the patient stated that her daughter hires prostitutes for her husband. Overall, Ms. Bravo de Mata demonstrated full cooperation and appeared to put forth her best effort throughout the evaluation. Thus, the results appear to provide an accurate representation of her current level of neuropsychological functioning.

TESTS ADMINISTERED

Escala de Inteligencia de Wechsler para Adultos-IV (select subtests)
Ponton-Satz Boston Naming Test
Lexical Fluency (PMR)
Golden Stroop
Symbol Digit Modality Test (Motor)
WHO-UCLA Auditory Verbal Learning Test
Trail Making Test
Logical Memory I and II (WMS-IV Spanish)
Rey Complex Figure Test
Clock Drawing Test
Finger Tapping Test
Escala de Aculturación Bidimensional
Escala de Dominancia Bilingüe
Geriatric Depression Scale- SF (Spanish)
Generalized Anxiety Disorder (GAD-7) (Spanish)
Dementia Severity Rating Scale
Activities of Daily Living Scale
Neuropsychiatric Inventory Questionnaire

TEST RESULTS

The patient was interviewed in Spanish by a bilingual Neuropsychologist. A bilingual technician administered all objective tests in Spanish. The patient's cultural background (e.g., Spanish first language, born and raised in Venezuela, level of acculturation, and level of educational attainment) was taken into consideration in interpreting her performance on the neuropsychological evaluation. Whenever possible, measures that have been developed and normed for Spanish-speaking individuals were utilized. If not available, the best available norms were used. With this caveat in mind, the major findings with respect to Ms. Bravo de Mata's neurocognitive functioning are summarized below.

Language Dominance and Acculturation: Results from cultural and linguistic questionnaires indicate that the patient is definitively dominant in the Spanish language, which she acquired during early childhood. She demonstrates a strong bidirectional acculturation orientation toward Hispanic culture, with minimal orientation toward Anglo culture. Qualitatively, Spanish is utilized almost exclusively across all primary domains of daily life, including internal mental operations, social communication, and media consumption. She reported very low functional proficiency and minimal comfort with her secondary language, English, and indicated that if restricted to using only one language for the remainder of her life, she would unequivocally choose Spanish. Consequently, these cultural and linguistic findings clinically justify the utilization of the Spanish language for the current neuropsychological evaluation.

Attention/Processing Speed: Immediate recall of an orally presented number sequence was below average for digits forward and reverse, and exceptionally low for digits in sequence.

Graphomotor speed was exceptionally low. Speeded word reading and color naming were both in the exceptionally low range.

Language: Visual object naming was in the exceptionally low range. Lexical fluency was in the exceptionally low range as well.

Visuospatial/Constructional: Her ability to copy a complex figure was average. On a measure of graphomotor clock drawing, the patient's free-drawn attempt revealed an intact but slightly irregular contour with severe spatial crowding and poor distribution of numbers along the right and lower boundaries. When provided with a visual model in the copy condition, these spatial distribution errors were largely resolved, resulting in a more proportionate layout. This performance pattern suggests a secondary organizational issue rather than a primary visuospatial constructional vulnerability, given her ability to benefit from the external visual structure.

Learning and Memory: Immediate recall of unstructured verbal material (15-word list) was in the exceptionally low range, characterized by a flattened learning curve across five consecutive trials (3, 4, 5, 5, and 6 words, respectively) and the presence of several intrusion errors. Following the presentation of a distractor list, her free recall of the primary list remained exceptionally low (4 out of 15 words). After a 20-minute delay, her spontaneous recall was nil, placing her performance in the exceptionally low range. On a subsequent delayed recognition paradigm, her performance was impaired; while she identified all 15 target words, she exhibited a severe positive response bias by endorsing 15 false-positive errors, indicating a pronounced breakdown in discriminability and source monitoring.

When presented with structured verbal material (prose passages), her immediate recall was in the exceptionally low range. Following a delay, she was unable to spontaneously recall any details from the stories (nil), which normatively fell within the below average range. Her ability to recognize story elements on a forced-choice discrimination task was mildly reduced, performing in the below average to low average range.

On a measure of unstructured visuospatial learning and memory, the patient's three-minute delayed recall of a complex geometric design was in the below average range, despite an initial copy performance that was within the average range. Following a thirty-minute delay, her free recall declined further to the exceptionally low range. Notably, her rate of memory retention over the extended delay period was exceptionally low, demonstrating rapid and significant decay of the newly encoded visual material.

Executive Functions: On a measure of simple visual scanning and psychomotor sequencing, the patient's performance was exceptionally low for speed, albeit error-free. She was unable to successfully execute a complex cognitive set-shifting task (alternating number-letter sequencing) due to a fundamental inability to comprehend the instructional parameters. Her cognitive flexibility and inhibitory control were similarly compromised on a color-word interference paradigm, which she could not complete due to a severe inability to suppress prepotent verbal responses. Additionally, her capacity for verbal abstract reasoning and conceptualization fell within the below average range.

On a measure of graphomotor clock drawing, executive planning and organizational elements in the free-draw condition were profoundly impaired. This was characterized by severe number sequencing errors extending beyond twelve and the placement of only a single hand, thereby failing to denote a specific time or differentiate hand length. During the copy condition, however, all planning, conceptual, and sequencing errors were successfully corrected, including the accurate placement of two distinct hands to appropriately denote the modeled time. Consequently, the initial errors point to a pronounced executive planning and retrieval deficit rather than a fundamental loss of semantic knowledge regarding the conceptual features of a clock.

Motor Abilities: The patient is right hand dominant. Fine motor dexterity was exceptionally low bilaterally.

Emotional/Behavioral Functioning: Ms. Bravo de Mata endorsed moderate to severe symptoms of depression on a self-report inventory of mood. She also endorsed severe anxiety symptoms on a separate self-report inventory of mood.

SUMMARY

Ms. Nilda Bravo de Mata is a 74-year-old, right-handed Hispanic female with 12 years of formal education who was referred for a neuropsychological evaluation by Ms. Melanie Roberts-Boyd, APRN, to assess suspected cognitive decline. The husband reported a progressive worsening of cognitive difficulties, notably memory loss, severe spatial disorientation, and functional decline, with symptoms explicitly noted to have accelerated around December 2024. During the evaluation, she presented with a flat affect and required simplified instructions and occasional reminders, but she demonstrated full cooperation and appeared to put forth her best effort. Consequently, the current evaluation is considered a valid representation of her present neurocognitive functioning.

Regarding intact cognitive abilities, Ms. Bravo de Mata demonstrated a narrow range of preserved functioning, primarily within the visuospatial domain when external structure was provided. Specifically, her ability to copy a complex geometric figure was within the average range. Similarly, while her spontaneous graphomotor clock drawing was disorganized, the provision of a visual model in the copy condition largely resolved these spatial distribution errors, indicating that her fundamental visuospatial constructional abilities remain relatively intact when executive and organizational demands are minimized.

In contrast to these isolated strengths, Ms. Bravo de Mata exhibited profound, multi-domain cognitive impairments. Her simple attention ranged from below average to exceptionally low, and all measures of processing speed, including graphomotor tracking and speeded naming, were exceptionally low. Language functioning was significantly compromised, with confrontational naming and lexical fluency falling in the exceptionally low range. Learning and memory systems are severely impaired; she demonstrated a flattened learning curve for unstructured verbal material, with nil spontaneous delayed recall and a severe positive response bias on recognition, indicating a breakdown in source monitoring. Visuospatial memory similarly revealed rapid and significant decay. Executive dysfunction was pervasive, characterized by exceptionally low simple sequencing speed, profound failure on complex set-shifting due to comprehension

deficits, severe inhibitory control failures, and profound planning and organizational errors on unstructured tasks. Bilateral fine motor dexterity was also exceptionally low.

Emotionally and behaviorally, Ms. Bravo de Mata is experiencing severe psychiatric and mood disturbances. On self-report inventories, she endorsed moderate to severe symptoms of depression and severe anxiety. During the clinical interview, she reported frequent suicidal ideation, though she denied an active plan, citing her grandson as a strong protective factor. Furthermore, she exhibits significant psychotic symptoms, including visual and auditory hallucinations, as well as severe delusions of misidentification and infidelity regarding her husband. Active delusional thought content was also explicitly observed during the psychometric evaluation, as she spontaneously reported that her daughter hires prostitutes for her husband.

Functionally, Ms. Bravo de Mata experiences severe global decline and is highly dependent on her husband for daily survival. She requires physical assistance with all basic activities of daily living, including dressing, bathing, and personal hygiene, and she is currently incontinent for both urinary and fecal matter. She requires comprehensive supervision and assistance for all instrumental activities of daily living, including shopping, telephone use, and cooking, due to safety concerns such as previously leaving the stove unattended. Her husband manages her finances, medical appointments, and medication administration, though she occasionally exhibits non-compliance with her prescribed regimen due to behavioral resistance.

Ms. Bravo de Mata’s overall cognitive profile is characterized by severe, global neurocognitive impairment with pervasive deficits in memory, executive functioning, processing speed, and language, alongside relatively spared guided visuospatial copy skills. This pattern of profound cognitive decline, combined with pronounced psychiatric disturbances (hallucinations, delusions of misidentification) and severe functional dependence, reflects a significant and advanced neurodegenerative disease process. Given her complex medical history—which includes Stage IV chronic kidney disease, a history of cerebrovascular accidents, myocardial infarction, and extensive cardiovascular disease—her presentation is highly consistent with a mixed etiology dementia. The findings firmly support her recent medical diagnosis of Major Neurocognitive Disorder due to mixed etiologies (Moderate Alzheimer's disease and Vascular Dementia), complicated by prominent behavioral and psychological symptoms of dementia.

IMPRESSION Major Neurocognitive Disorder due to mixed etiologies (Moderate Alzheimer's disease and Vascular Dementia), with behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety

RECOMMENDATIONS

To ensure accessibility and support patient adherence, a Spanish-language version of these recommendations is provided at the conclusion of this report. This section has been culturally and linguistically adapted into a user-friendly format for Ms. Bravo de Mata; as such, the phrasing differs from the technical English recommendations intended for the clinical team.

Medical & Psychiatric Management

1. **Urgent Psychiatric Re-evaluation:** Given her diagnosis of Major Neurocognitive Disorder with prominent psychotic and mood disturbances, Ms. Bravo de Mata requires immediate and ongoing psychiatric management. At her upcoming appointment with Dr. Gretel Salazar, it is critical that the family explicitly report her active suicidal ideation, worsening visual and auditory hallucinations, and severe delusions of misidentification (e.g., failing to recognize her husband). Medication adjustments (e.g., optimizing her current Risperidone and Sertraline regimen) are necessary to mitigate these behavioral and psychological symptoms of dementia (BPSD) and reduce her distress.
2. **Vascular Risk Factor Management:** Due to the mixed etiology of her dementia (Vascular and Alzheimer's) and her extensive medical history—including Stage IV chronic kidney disease, prior cerebrovascular accidents (strokes), myocardial infarction, and diabetes—strict medical management is imperative to prevent further vascular brain injury. She must maintain close follow-up with her primary care physician, neurologist, and relevant specialists to rigorously control her blood pressure, lipid levels, and glycemic indices.
3. **Medication Administration:** Because of her profound cognitive impairment, inability to manage her regimen, and noted behavioral resistance to taking pills, her husband must continue to retain absolute control over medication administration. To circumvent her non-compliance, the family should consult her prescribing providers about the safety of utilizing liquid formulations or crushing medications into preferred foods, provided there are no pharmacological contraindications.

Safety & Supervision

1. **Round-the-Clock Supervision:** Ms. Bravo de Mata requires 24/7 supervision to ensure her physical safety. Due to her profound executive dysfunction, severe memory impairment, and significant spatial disorientation, she must not be left alone under any circumstances.
2. **Wandering and Elopement Precautions:** In light of her recent wandering episode that resulted in police intervention, strict environmental modifications are necessary. The family should install door alarms on all exterior doors, place complex locks high and out of her direct line of sight, and equip her with a wearable GPS tracking device or medical alert bracelet.
3. **Kitchen and Household Safety:** Given her history of leaving the stove unattended and her exceptionally low processing speed and planning abilities, she must be restricted from independent cooking or appliance use. Stove knobs should be removed when not in use by a caregiver, or automatic shut-off devices should be installed.

4. **Fall Prevention and Mobility:** Because she demonstrates motor slowing, a formal in-home safety evaluation by an Occupational or Physical Therapist is recommended. This will help identify environmental hazards (e.g., loose rugs) and determine the need for adaptive equipment, such as grab bars in the bathroom, to accommodate her physical decline and dual incontinence.

Cognitive & Behavioral Strategies

1. **Managing Delusions and Hallucinations:** Caregivers should be educated on the use of validation therapy. When she experiences hallucinations or delusions of misidentification (e.g., believing her husband is an imposter or uncle), caregivers must avoid directly arguing, reasoning, or correcting her, as this will likely escalate agitation and paranoia. Instead, caregivers should validate her underlying emotional state (e.g., fear or confusion), offer gentle reassurance, and smoothly redirect her attention to a comforting, highly familiar activity.
2. **Communication Modifications:** Due to her definitively dominant Spanish language preference, exceptionally low processing speed, and compromised verbal fluency, all communication should be simplified. Caregivers should speak slowly and clearly in Spanish, use short and direct sentences, and allow ample time for her to process information and formulate a response. Open-ended questions should be replaced with simple binary choices (e.g., offering a choice between two specific clothing items).
3. **Structuring ADLs:** To assist with her dependence in all basic activities of daily living, caregivers should establish a highly structured, predictable daily routine. Breaking down tasks (such as dressing or hygiene) into simple, single-step instructions will help bypass her severe executive sequencing deficits and reduce behavioral resistance.

Functional & Legal Planning

1. **Caregiver Support and Respite:** Her husband is currently providing highly intensive, comprehensive care, placing him at severe risk for caregiver burnout. It is strongly recommended that the family actively explore home health nursing assistance, respite care options, or adult day programs equipped for advanced dementia to provide him with necessary relief. Connecting with local caregiver support groups for Alzheimer's and related dementias is also highly encouraged.
2. **Legal and Financial Directives:** As she has lost the capacity to manage finances, make complex medical decisions, or live independently, it is imperative that her legal and financial affairs are formally secured. If not already completed, the family should consult with an elder law attorney to establish or update a Durable Power of Attorney and Medical Power of Attorney, ensuring her husband or another designated proxy has the legal authority to seamlessly manage her care and estate.

Thank you for this kind referral.

Claudia V. Resendiz
Claudia V. Resendiz, Ph.D., ABPP
Board Certified, American Board of Clinical Neuropsychology

Electronically signed: 07/15/2026

RECOMENDACIONES PARA EL CUIDADO Y BIENESTAR DE LA SRA. NILDA

Estas recomendaciones han sido diseñadas pensando en la familia, con el objetivo de brindarles herramientas prácticas para apoyar a la Sra. Nilda de la forma más segura y amorosa posible.

Manejo Médico y Psiquiátrico

1. **Cita prioritaria con psiquiatría:** Es muy importante que hablen con la Dra. Gretel Salazar sobre los pensamientos recientes de la Sra. Nilda de no querer vivir, así como de las visiones (alucinaciones) y las confusiones sobre quién es su esposo. Ajustar sus medicamentos (como la Risperidona y la Sertralina) le ayudará a sentirse más tranquila y con menos miedo o angustia.
2. **Cuidado de su salud física:** Debido a su historial médico (problemas de riñón, derrames cerebrales, problemas del corazón y diabetes), es fundamental seguir en control estricto con sus médicos regulares. Mantener estables su presión arterial, colesterol y niveles de azúcar protegerá su cerebro de futuros daños.
3. **Administración de medicamentos:** Dado que la Sra. Nilda a veces no quiere tomar sus pastillas debido a la confusión, el Sr. Nelson debe seguir controlando y entregando todas las medicinas personalmente. Pueden preguntar a sus médicos si existe la opción de darle los medicamentos en forma líquida o triturados en sus alimentos favoritos para facilitar este proceso, siempre y cuando sea seguro hacerlo.

Seguridad y Supervisión

1. **Acompañamiento continuo (24/7):** Para protegerla, la Sra. Nilda nunca debe quedarse sola en casa. Necesita supervisión constante debido a sus problemas de memoria, desorientación espacial y dificultades de juicio.
2. **Prevención de salidas o pérdidas:** Recordando el incidente donde se desorientó y caminó a la casa de un vecino, les sugerimos instalar alarmas en las puertas exteriores y poner cerraduras complejas (o en una posición alta fuera de su alcance visual). También es altamente recomendable el uso de una pulsera de alerta médica o un localizador GPS.
3. **Seguridad en la cocina:** Como ha dejado la estufa encendida en el pasado, ella ya no debe cocinar sin supervisión constante. Es recomendable quitar las perillas de la estufa cuando no se esté utilizando o instalar un sistema de apagado automático.
4. **Prevención de caídas y movilidad:** Ya que ella utiliza silla de ruedas y andador, y ha tenido caídas recientes, sugerimos pedir a su médico una evaluación en casa por parte de un Terapeuta Físico u Ocupacional. Ellos pueden ayudar a adaptar la casa para evitar accidentes, por ejemplo, instalando barras de apoyo en el baño para mayor seguridad.

Estrategias de Comunicación y Comportamiento

1. **Cómo manejar la confusión o alucinaciones:** Cuando la Sra. Nilda tenga visiones o crea que su esposo es otra persona (como un tío o un extraño), es vital no discutir, corregirla ni intentar convencerla de la realidad, ya que esto le causará más estrés. En su lugar, validen sus emociones (ej. "Sé que estás asustada, pero yo estoy aquí para

cuidarte"), denle consuelo y cambien suavemente de tema hacia una actividad o recuerdo que a ella le traiga paz.
2. **Comunicación más sencilla:** Debido a que su mente procesa la información más lentamente, háblenle siempre de forma calmada, despacio y con oraciones cortas. Denle tiempo suficiente para entender y responder. En lugar de hacerle preguntas abiertas, ofrézcanle opciones simples (por ejemplo, "¿Prefieres ponerte esta blusa azul o la roja?").
3. **Rutinas paso a paso:** Para ayudarla con las actividades diarias, como su higiene personal y vestido, mantengan una rutina muy predecible. Divídanle las tareas en pasos muy sencillos y denle una sola instrucción a la vez para que no se sienta abrumada.

Apoyo Familiar y Planificación Legal

1. **Apoyo para el Sr. Nelson (Cuidador principal):** Cuidar a un ser querido con esta condición es un trabajo profundamente agotador, y el Sr. Nelson está haciendo un esfuerzo inmenso asumiendo todas las responsabilidades. Es muy importante buscar ayuda (por ejemplo, agencias de cuidado en el hogar / *Home Health*, programas de día para adultos mayores, o ayuda de familiares) para que él pueda descansar. Recomendamos fuertemente que se unan a un grupo de apoyo local para familias con Alzheimer.
2. **Documentos legales y financieros:** Como la Sra. Nilda ya no tiene la capacidad para manejar el dinero o tomar decisiones médicas complejas, es fundamental asegurar que los poderes notariales (*Power of Attorney* y *Medical Power of Attorney*) estén actualizados. Esto garantizará que el Sr. Nelson o sus representantes designados tengan toda la autoridad legal para tomar decisiones sobre su salud y sus finanzas sin ningún obstáculo en el futuro.