Home Health Certification and Plan of Care

Order ID: 1150/17142

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
94221657	03/14/2026	From: 03/14/2026 To: 05/12/2026	23575	217058

6. Patient's Name and Address
Lakeria Burrell
3807 FLOWERTON ROAD,
BALTIMORE, MD 21229-
443-546-8282

7. Provider's Name, Address and Telephone Number
HomeCentris Healthcare LLC
10 Crossroads Drive, Suite 102
Owings Mills, MD 21117-8284
410-321-8448
1487113239

8. DOB 12/11/1986 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
Z48.3	Aftercare following surgery for neoplasm	03/14/26

13. ICD	Other Pertinent Diagnoses	Date
D35.2	Benign neoplasm of pituitary gland	03/14/26
E22.1	Hyperprolactinemia	03/14/26
H43.819	Vitreous degeneration unspecified eye	03/14/26
N91.5	Oligomenorrhea unspecified	03/14/26
E66.9	Obesity unspecified	03/14/26
Z68.36	Body mass index [BMI] 36.0-36.9 adult	03/14/26
Z79.01	Long term (current) use of anticoagulants	03/14/26
Z79.4	Long term (current) use of insulin	03/14/26
Z79.52	Long term (current) use of systemic steroids	03/14/26
Z79.891	Long term (current) use of opiate analgesic	03/14/26

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

White Petrolatum Mineral Oil (LUBRICANT EYE) 0 83-15 % Opht Oint left eye three times a day Use especially at night before bed; you may want to cover with eye patch at night
Roxicodone - Oxycodone Hydrochloride 5 mg 5 mg 5 mg / 1 Tablet by mouth every 6 hours as needed for MODERATE Pain (or if patient requests it for severe pain).
norethindrone e.estradiol-iron (FEIRZA) 0 1 mg-20 mcg (21) / 75 mg (7) / 1 Tablet by mouth once a day Take 1 tablet by mouth daily
KEPPRA 1,000 mg / 1 Tablet by mouth twice a day SEIZURES
Cortef - Hydrocortisone 5 mg 5 mg by mouth once a day Take 9 tablets by mouth daily for 3 days, THEN 6 tablets daily for 3 days, THEN 3 tablets daily. Do not start before March 10, 2026.
Cortef - Hydrocortisone 5 mg 5 mg 5 mg 5 mg / 1 Tablet by mouth once a day T ake 3 tablets by mouth every evening for 3days, THEN 2 tablets every evening for 3days, THEN 1 tablet every evening. Do not start before March 10, 2026.

14. DME and Supplies:
walker

15. Safety Measures:
ambulates with device, walker precautions, , ambulates with assistance, supervision at all times, activity supervision

16. Nutrition:
Z. NO PHYSICIAN-ORDERED DIET

17. Allergies:
no known allergies

18.A. Functional Limitations
Endurance, Ambulation, RIGHT EYE DECREASED VISUAL ACUITY

18.B. Activities Permitted
Up As Tolerated, , Exercises Prescribed, Walker

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

20. Prognosis: fair

22. A Rehabilitation Potential:
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

22.B.Discharge Plans
family/caregiver will be responsible for managing treatment

Homebound status: After undergoing Left Pterional Craniotomy For Suprasellar Lesion Resection Pituitary Mass, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device.

Clinical Condition Requiring Homecare:

The patient is a 39-year-old female recently discharged home following hospitalization for a left pterional craniotomy with resection of a suprasellar pituitary mass performed on 03/03. Her past medical history is significant for pituitary adenoma with prior resection in July 2025, anemia, seizure disorder, chronic headaches, hyperprolactinemia, obesity, right retinal detachment, and oligomenorrhea. She resides with her spouse and teenage son in a two-story home with bedroom and bathroom located on the second floor. Prior to her recent illness, the patient was independent and employed as a security guard. At the time of assessment, the patient is alert and oriented to person, place, and time (A&O3). She reports left-sided facial pain rated at 7/10 and ongoing blurry vision in the right eye. She denies shortness of breath and reports a fair appetite, with last bowel movement occurring on the day of assessment. Physical examination reveals a closed left anterior cranial incision with dissolvable sutures in place, which appears clean, dry, and intact without signs or symptoms of infection. The patient demonstrates unsteady gait and impaired balance, utilizing a rollator for safety during mobility, particularly outdoors. Functionally, the patient is able to ambulate approximately 30 feet indoors without an assistive device and can negotiate 14 steps with the use of a handrail under supervision. Bed mobility and transfers to bed, chair, and toilet are performed with supervision. Despite this, she remains at increased fall risk as evidenced by a Tinetti score of 20/28 and is considered homebound due to the significant effort required to leave the home safely. Skilled nursing services were initiated with a frequency of once weekly for 12 weeks, followed by tapering as indicated. Nursing interventions included comprehensive medication reconciliation and education regarding medication dosing, frequency, and potential side effects, with medication management currently overseen by the spouse. Education was also provided on incision care and recognition of warning signs requiring medical attention, including worsening headaches, changes in vision, increased imbalance, or other neurological symptoms. Both the patient and spouse demonstrated understanding and were receptive to all instructions. The patient has a scheduled follow-up appointment with her primary care provider. Occupational therapy evaluation determined that the patient is independent with basic self-care tasks including grooming, dressing, and bathing, with family assistance for instrumental activities of daily living such as meal preparation and household tasks. Upper extremity strength is good, and activity tolerance is fair. No further skilled occupational therapy services are indicated at this time. Physical therapy services are recommended to address deficits in strength, balance, and mobility, with the goal of restoring prior level of function and ensuring safe ambulation.
 Date of Order 03/14/2026 Orders Physician Face-to-Face Date: 03/09/2026 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Left Pterional Craniotomy For Suprasellar Lesion Resection Pituitary Mass Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home
 1 - SOC - SN Notes: soc PT Eval Notes: OT Eval Notes:
 Physician Madah, Maria

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 03/14/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Maria Madah
1701 Twin Springs Rd
Halethorpe, MD 21227
PHONE: (800) 777-7904 FAX: 18559024974 NPI: 1952892846

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
F2F date : 03/09/2026

27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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SN WK1: 8 (03/14/26-03/14/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance

HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications, 8. Currently reports exhaustion, 9. Other risk(s) not listed in 1- 8

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.
Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.
Provide education content at patient's level of health literacy.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.
Assess: Musculoskeletal status.
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:No Advance Directive

PROBLEMS IDENTIFIED ON ASSESSMENT: M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited endurance, limited strength, Pain Interference with ADLs, headache, balance deficit, B1000 - Vision Deficit, obesity, rough/scaly/cracked skin, #1 - Other - Other - LEFT CLOSED CRANIAL INCISION ANTERIOR ASPECT -

PROCEDURES: physician-ordered wound care: #1 - Other - Other - LEFT CLOSED CRANIAL INCISION ANTERIOR ASPECT -: open to air, coordinate/arrange resources for vision-impaired

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals

PATIENT-STATED GOAL: I want to get stronger and start exercises

GOALS
patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* strategies to minimize fatigue and exhaustion including work simplification
* energy conservation
* lifestyle changes
* diet
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

meal preparation is available to patient for all meals

PT Careplans

PT WK2: 1 (03/15/26-03/21/26) ,WK3: 1 (03/22/26-03/28/26) ,WK4: 1 (03/29/26-04/04/26) ,WK5: 1 (04/05/26-04/11/26) ,WK6: 1 (04/12/26-04/18/26) ,WK7: 1 (04/19/26-04/25/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object

PROCEDURES: Home exercise program : Supine hip flexion, bridging, hooklying rotation,

PT Goals

PATIENT-STATED GOAL: Tolerates able to see like normal and be able to walk

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Messick, Charles RN

Date
03/14/2026

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straight leg raise, hip abduction. Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension and ankle pumps. , gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent

* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

Sit to Stand - 06. Independent

OT Careplans

OT WK2: 1 (03/15/26-03/21/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating

PROCEDURES: cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT Goals

PATIENT-STATED GOAL: to go back to work

GOALS
patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	03/14/2026