Home Health Certification and Plan of Care

Order ID: 1163/770

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
511080789	01/29/2026	From: 01/29/2026 To: 03/29/2026	1047	497754

6. Patient's Name and Address
Meenu Kochhar
1408 Summerfield Dr,
HERNDON, VA 20170-
703-625-6818

7. Provider's Name, Address and Telephone Number
Grace Home Healthcare, LLC
9735 Main Street Suite 200 Fairfax,
Fairfax, VA 22031-3736
703-865-7370
1073904009

8. DOB 09/15/1961 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
N39.0	Urinary tract infection site not specified	01/29/26

13. ICD	Other Pertinent Diagnoses	Date
B96.20	Unsp Escherichia coli as the cause of diseases classd elswhr	01/29/26
R78.81	Bacteremia	01/29/26
G30.0	Alzheimer's disease with early onset	01/29/26
F02.80	Dem in oth dis classd elswhrunsp sevw/o beh/psych/mood/anx	01/29/26
L43.9	Lichen planus unspecified	01/29/26
K59.09	Other constipation	01/29/26

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

Senakot - Senna 8.6-50mg 1 table by mouth at bedtime Constipation
Melatonin - Melatonin 3 mg 2 tables by mouth at bedtime Insomnia
Depakote - Divalproex Sodium eq 250 mg valproic acid 1 Tablet by mouth twice a day Mood swing
Aricept - Donepezil Hydrochloride 5 mg 1 Tablet by mouth at bedtime Dementia
Acetaminophen - Acetaminophen 500 mg 2 tablets by mouth every 6 hours Mild pain
Pristiq - Desvenlafaxine Succinate eq 50 mg base eq 50 mg base1 Tablet by mouth twice a day Depression

14. DME and Supplies:
bath bench, hand held shower, grab bars

15. Safety Measures:
infectious material management, hand rails, , bathroom safety, activity supervision

16. Nutrition:
regular

17. Allergies:
no known allergies

18.A. Functional Limitations
Ambulation, Endurance, Bowel/Bladder Incontinence

18.B. Activities Permitted
Up As Tolerated

19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 2. On awakening or at night only, SOCIAL ISOLATION: 8. Patient unable to respond, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required!2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions, HISTORY OF DEPRESSION: No

20. Prognosis: good

22. A Rehabilitation Potential:
SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

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

Homebound status: Due to diagnosis of Urinary Tract Infection Site Not Specified, 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:

Start of care and physical therapy evaluation were completed for this 64-year-old Indian female following recent hospitalization for weakness and confusion, during which she was diagnosed and treated for a multidrug-resistant (MDR) E. coli urinary tract infection complicated by gram-negative rod bacteremia. She was discharged home with intravenous antibiotics via a single-lumen midline catheter in the right upper extremity. Her past medical history is significant for dementia, Alzheimer's disease, recurrent urinary tract infections, unspecified E. coli infection, bacteremia, lichen planus, and constipation. Immunizations are up to date, including influenza vaccination in October 2025 and current pneumococcal vaccination. The patient resides with her husband in a multilevel home and receives additional assistance from a family friend who provides approximately four hours of unpaid caregiving daily. During the nursing visit, intravenous antibiotic therapy was administered via the right arm midline over a 30-minute infusion without complication. The midline catheter site was assessed and noted to have one lumen, intact and patent. The patient's husband, who primarily speaks Punjabi and communicates directly with the patient, was educated extensively on midline care, flushing technique, monitoring for complications, and appropriate actions should the line become dislodged, as the patient was observed attempting to pull at the IV tubing during the visit. Due to cognitive impairment and confusion, the patient is at high risk for accidental line removal. The husband demonstrated appropriate understanding of midline management, including flushing technique, and verbalized comprehension of emergency procedures if dislodgement occurs. Per physician order, no blood pressure measurements are to be taken in the right arm. On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was awake but disoriented to time, place, and self, and does not consistently follow commands. She was largely nonverbal during the visit but responded to her husband's voice by moving her head. No facial grimacing or outward signs of pain were noted. Pupils were equal and reactive to light. Facial symmetry was intact, and bilateral hand grasps were equal. Posterior lung fields were clear to auscultation without use of accessory muscles. The abdomen was distended but soft and non-tender, with active bowel sounds in all four quadrants. Bilateral lower extremities were without edema. The patient is occasionally incontinent of bladder. She is able to ambulate with supervision but requires assistance for stair navigation due to safety concerns and cognitive impairment. The spouse manages medication administration, and the patient is able to feed herself with setup assistance. The spouse reports the patient uses Salonpas patches for bilateral knee pain management. Physical therapy evaluation reveals a decline in functional strength and mobility compared to prior level of function, as reported by the husband. The patient currently requires complete physical assistance for basic ADLs, including grooming, dressing, bathing, and toileting, as well as full assistance with medication and meal management secondary to advanced dementia and impaired cognition. She demonstrates decreased functional strength, balance, and overall mobility, placing her at increased risk for further decline and falls. Education was provided to the husband and caregiver regarding safe home setup, fall prevention strategies, stair safety, supervision requirements, and mobility within the home. A home exercise program was initiated, consisting of seated and standing bilateral lower extremity therapeutic exercises designed to improve strength, circulation, and functional mobility. Instruction included proper guarding techniques and safe positioning during exercise performance. The husband and caregiver verbalized understanding and agreement with the plan of care. Skilled nursing services remain medically necessary for continued intravenous antibiotic administration, midline monitoring, and caregiver education. Skilled physical therapy services are warranted to address deficits in strength, balance, endurance, and mobility, with goals focused on maximizing safety, preventing further functional decline, reducing fall risk, and supporting the patient and caregivers in maintaining the highest possible level of functional mobility within the context of progressive cognitive impairment.
 Date of Order 01/29/2026 Orders Physician Face-to-Face Date: 01/24/2026 Clinical Condition Requiring Home Care per Certifying Physician: SN-disease management PT-eval & treat OT-eval & treat HHA due to Urinary Tract Infection Site Not Specified 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 Ahmad, Umair

SN Careplans

SN Goals

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Messick, Charles RN on 01/29/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Umair Ahmad
1890 Metro Center Dr
Reston, VA 20190
PHONE: 7037091500 FAX: NPI: 1396033254

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 : 01/24/2026

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: 1 (01/29/26-01/31/26) ,WK2: 1 (02/01/26-02/07/26) ,WK3: 1 (02/08/26-02/14/26) ,WK4: 1 (02/15/26-02/21/26) ,WK5: 1 (02/22/26-02/28/26) ,WK6: 1 (03/01/26-03/07/26) ,WK7: 1 (03/08/26-03/14/26) ,WK8: 1 (03/15/26-03/21/26) ,WK9: 1 (03/22/26-03/28/26)

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: 4. Multiple emergency department visits (2 or more) in the past 6 months, 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion

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; 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: , M1745 - Behavioral Issues, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, M1600 - UTI, M1610 - Urinary Incontinence, frequent urination, muscle weakness, limited endurance, limited range of motion, limited strength, balance deficit

PROCEDURES: CBC without , Chem 7 weekly: CBC without Diff, Chem 7, cough/deep breathing exercises: Unable to follow commands, coordinate/arrange caregiver support to prevent caregiver physical, emotional and mental exhaustion: Husband demonstrated understanding, coordinate/arrange preparation of missing meals: Family assist

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 medicatio, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s, * prevention including increase fluid intake increase Vitamin C intake to promote acidic bladder environment (cranberry juice) perineal hygiene, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, 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 my wife to finish the antibiotics

GOALS
patient/caregiver recalls
* prevention including increase fluid intake
* increase Vitamin C intake to promote acidic bladder environment (cranberry juice)
* perineal hygiene
* 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 medicatio

patient/caregiver recalls
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* recalls related medication(s

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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 WK1: 10 (01/29/26-01/31/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: 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: Seated/Standing therex BLE, 2x10, 1-2x/daily: sit to stands, marches, LAQ, clams, hip add with pillow squeezes, HR/TR, standing SLR hip abd/ext, standing marches, home exercise program: Seated/Standing therex BLE, 1-2x10, 1-2x/daily: sit to stands, marches, LAQ, clams, hip add with pillow squeezes, HR/TR, standing SLR hip abd/ext, standing marches, home exercise program: Seated/Standing therex BLE, 1-2x10, 1-2x/daily: sit to stands, marches, LAQ, clams, hip add with pillow squeezes, HR/TR, standing SLR hip abd/ext, standing marches, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 05. Setup or clean-up assistance, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance

PT Goals

PATIENT-STATED GOAL: Per word of husband on pt's behalf: to build her strength back to willingness to walk around home more and overall general strength and function back to her pre hospitalization status

GOALS
Sit to Stand - 05. Setup or clean-up assistance

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

OT Careplans

OT WK1: 1 (01/29/26-01/31/26)

PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, 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

OT Goals

PATIENT-STATED GOAL: OT evaluation only

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 medicatio

Signature of Physician:

Date

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

Date
01/29/2026

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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 medicatio, * 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 relaxatio, Oral Hygiene - 01. Dependent, Toileting Hygiene - 01. Dependent, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 01. Dependent, Lower Body Dressing - 01. Dependent, Don/Doff Footwear - 01. Dependent, Eating - 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
* teach relaxatio

Oral Hygiene - 01. Dependent

Toileting Hygiene - 01. Dependent

Shower/Bathe Self - 03. Partial/moderate assistance

Upper Body Dressing - 01. Dependent

Lower Body Dressing - 01. Dependent

Don/Doff Footwear - 01. Dependent

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/29/2026