

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157095 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 11/21/2013 |
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| NAME OF PROVIDER OR SUPPLIER MEMORIAL HOME CARE INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3355 DOUGLAS RD STE 100 SOUTH BEND, IN 46635 | | |
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| G000000 | <p>This was a partial extended federal home health recertification survey.</p> <p>Survey Dates: November 18, 19, 20, and 21, 2013</p> <p>Facility #: 005298</p> <p>Medicaid Vendor #: 100091080A</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Census: 3702 skilled patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 26, 2013</p> | G000000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| G000158 | <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review, agency policy review, and interview, the agency failed to ensure homemaker visits were made as ordered on the plan of care in 1 of 2 records reviewed of patients receiving homemaker services creating the potential to affect all patients of the agency receiving homemaker services. (#15)</p> <p>Findings include:</p> <p>1. Clinical record #15, start of care 8/28/13, contained a plan of care for certification period 10/27/ to 12/25/13 with physicians orders for homemaker services 1 time per week for 7 weeks. The clinical record failed to evidence homemaker visits were made for weeks 1 and 2.</p> <p>A. The record contained an undated document titled "Missed Visit Sheet" signed by employee O (registered nurse) which states, "The HMKR [homemaker] was not able to see your patient on week of 11/2/13 + [and] 11/9/13 for the following reason: unable to re-staff due</p> | G000158 | <p>When it is known in advance that a scheduled employee will not be able to provide the services ordered, schedulers and/or managers will identify and schedule other associates capable of providing the ordered services. Actions taken to identify and schedule other associates will be documented by the schedulers/managers. Going forward all instances when an associate is unable to work their scheduled shift or visit will be reported in writing to the appropriate manager (Nurse Manager for Nurse shift coverage; Aide Manager for Aide shift coverage; Therapy Manager for Therapy shift coverage) inclusive of how the shift was eventually covered. These reports will be used to identify hiring needs and when the agency experiences shortages in staff that information will be given to referring sources noting the agency is unable to staff their needs which would preclude acceptance of the referral. Managers will report to Director/Administrator, these instances and subsequent hiring or needed staff. By 12/27/13 all staff involved in scheduling will</p> | 12/27/2013 | |

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| | <p>to call off." The record failed to evidence attempts for replacement of the service.</p> <p>B. On 11/21/13 at 1 PM, employee A indicated homemaker services were not provided to the patient for weeks 1 and 2 but the physician was notified. The employee was unable to provide documentation of attempts for replacement of the service.</p> <p>2. Agency policy with effective date of 7/92 and last revision date of 5/12 titled "Patient/Client care plan" states, "Objective: To have in effect, on a timely basis, a care plan based on both the initial and ongoing patient/client assessments, that is designed to: 1. Comply with the attending physician's orders ... "</p> | | <p>have been given this information and instructions to follow these procedures when faced with unstaffed periods of care. Diane Whitcomb, Director/Administrator will be responsible for assuring these measures are being followed.</p> | | |

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| G000159 | <p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and policy review, observation, and interview, the agency failed to ensure the plan of care included all the patient's equipment in 3 of 10 home visit observations with the potential to affect all the agency's patients. (#3, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record #3, start of care 11/1/13, included a plan of care for the certification period 11/1 to 12/30/13 that failed to include all patient equipment.</p> <p>A. On 11/19/13 at 9 AM, a home visit was conducted at which time the patient was observed using a cane. The cane was not listed on the plan of care.</p> <p>B. On 11/20/13 at 1:25 PM, employee C indicated the cane was not listed on the plan of care.</p> | G000159 | All agency clinicians will be in-serviced to identify all equipment in the patient/client home that is being used by the patient or agency associates in provision of care. Once identified, all equipment will be entered in the 485 or added via a physician's interim order if found after SOC, Recertification, or Resumption of services and if patient/client is using the equipment. Clinicians performing SOC, Recertification, ROC visits will be required to check for equipment prior to locking the OASIS/485. QA Nurse will review all SOC, ROC, Recertifications to assure all equipment listed in referral information is also listed on the 485 or ROC orders. Therapy Managers will perform ongoing medical chart reviews now through March 31, 2014, sampling at least 20 charts per month to assure this standard is being met. The goal is to be 100% compliant. If by 3/31/14 this goal has not been met, | 03/31/2014 | | | |

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| | <p>2. Clinical record #8, start of care 11/1/13, included a plan of care for the certification period 11/1 to 12/30/13 that failed to include all patient equipment.</p> <p>A. On 11/19/13 at 10:20 AM, a home visit was conducted at which time employee M (occupational therapist) was observed using a gait belt to assist patient with therapy exercises. The gait belt was not listed on the plan of care.</p> <p>B. On 11/20/13 at 1:27 PM, employee C indicated the gait belt was not listed on the plan of care.</p> <p>3. Clinical record #9, start of care 11/1/13, included a plan of care for the certification period 11/1 to 12/30/13 that failed to include all patient equipment.</p> <p>A. On 11/19/13 at 3:15 PM, a home visit was conducted at which time employee K (physical therapist) was observed using a gait belt to assist patient with therapy exercises. The gait belt was not listed on the plan of care.</p> <p>B. On 11/20/13 at 1:34 PM, employee C indicated the gait belt was not listed on the plan of care.</p> <p>4. The agency policy effective 12/93 with</p> | | <p>review and monitoring will continue until the goal is met. This affected 3 current patients. Orders to add the assistive devices were received from their respective physicians and added to the POC via interim order. Therapists involved in the care in each of these cases instructed the patient on proper and safe use of the assistive device. Return demonstration was provided. This was achieved by the Therapy Manager and therapists as of 11/29/13. Diane Whitcomb, Director/Administrator will be responsible for seeing these procedures are followed and the goal is met.</p> | | | | |

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| | revision dates of 12/93, 3/94, 4/95, 11/95, 8/97, 12/98, 3/02, 1/03, 8/07, and 6/09 titled "Physician orders-plan of treatment" states, " Procedure: ... 2. The plan of treatment shall include, but not be limited to: ... O. equipment and supplies as needed." | | | |

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| G000236 | <p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the clinical notes in the record were signed and dated in 1 of 20 records reviewed. (#4)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #4, start of care 11/1/13, contained a document titled "Medication Profile." The document failed to evidence signature and date of discipline completing the medication review. <p>On 11/18/13 at 3:10 PM, employee A indicated the document should have been signed and dated by the personnel completing the review.</p> <ol style="list-style-type: none"> The agency policy with an effective date of 3/29/93 and last revision date of 2/03 titled "Record entry authentication" | G000236 | <p>At SOC all clinicians will be instructed to review documents to assure the medication record is signed and dated, either manually or electronically verified prior to locking the SOC, Recertification, and/or Resumption. Also, during QA review the QA nurse will check to make sure all medication records are signed or verified by the clinician who performed the visit. The QA Nurse and agency Managers will provide the instruction to all clinicians by 1/3/2014. Ongoing pre-billing and quality chart reviews will indicate 100% compliance with this plan of correction. This is and will continue to be a key quality and safety measure of the existing quarterly chart reviews. For purposes of measuring the effect of the plan of correction on this problem the agency will randomly review 20 medical records by 1/31/14 expecting 100% compliance. If this goal is not met 1:1 instruction will occur with</p> | 01/31/2014 | | | |

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| | states, "Policy: All entries into patient/client records shall be authenticated and dated and include title of person making entry." | | any clinician who has not demonstrated understanding and compliance and monitoring of those clinicians' charts will continue until 100% compliance is met. In the case of the record found unsigned during the survey, it was corrected prior to the end of the survey, 11/21/13. Diane Whitcomb, Director/Administrator will be responsible for compliance with this plan of correction and ongoing monitoring. | | |

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| G000332 | <p>484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Based on clinical record review, policy review, and interview, the agency failed to ensure the initial assessment visit was held within 48 hours of referral in 1 of 20 clinical records reviewed creating the potential to affect all new patients of the agency. (#16)</p> <p>Findings include:</p> <p>1. Clinical record #16, start of care 8/16/13, evidenced a referral to home care dated 8/13/13 and a comprehensive assessment on 8/16/13. The record failed to evidence an initial assessment was completed within 48 hours of the referral to identify immediate care needs.</p> <p>On 11/21/13 at 1:05 PM, employee A indicated the initial assessment was not completed within 48 hours of the referral.</p> <p>2. Agency policy with an effective date of 4/16/93 and revisions dated 4/93, 3/94, 12/95, 11/02, 3/03, 4/08, and 5/09 titled "Clinical Assessment/Reassessment" states, "Procedure: ... 3. The initial visit to the patient's residence will occur within 48 hours of acceptance of the referral."</p> | G000332 | Agency schedulers and supervisors will monitor referrals daily to assure they are scheduled and completed within 48 hours of receipt of MD orders or discharge from in-patient facility if patient remains hospitalized past the date the orders were received. All findings will be documented. This will be monitored for 3 months with the expectation the agency will show 100% compliance for at least 1 full continuous month. If this goal is not achieved monitoring will continue until it is met. Monitoring will be done by agency managers. This is and will continue to be a quality/service/safety measure in the agency's QA/Utilization Review and quarterly chart review program. Diane Whitcomb, Director/Administrator will be responsible for assuring compliance with this plan and goal achievement. | 03/31/2014 | | | |

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| N000000 | <p>This was a State home health re-licensure survey.</p> <p>Survey Dates: November 18, 19, 20, and 21, 2013</p> <p>Facility #: 005298</p> <p>Medicaid Vendor #: 100091080A</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 26, 2013</p> | N000000 | | | |

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| N000522 | <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, agency policy review, and interview, the agency failed to ensure homemaker visits were made as ordered on the plan of care in 1 of 2 records reviewed of patients receiving homemaker services creating the potential to affect all patients of the agency receiving homemaker services. (#15)</p> <p>Findings include:</p> <p>1. Clinical record #15, start of care 8/28/13, contained a plan of care for certification period 10/27/ to 12/25/13 with physicians orders for homemaker services 1 time per week for 7 weeks. The clinical record failed to evidence homemaker visits were made for weeks 1 and 2.</p> <p>A. The record contained an undated document titled "Missed Visit Sheet" signed by employee O (registered nurse) which states, "The HMKR [homemaker] was not able to see your patient on week of 11/2/13 + [and] 11/9/13 for the following reason: unable to re-staff due</p> | N000522 | <p>When it is known in advance that a scheduled employee will not be able to provide the services ordered, schedulers and/or managers will identify and schedule other associates capable of providing the ordered services. Actions taken to identify and schedule other associates will be documented by the schedulers/managers. Going forward all instances when an associate is unable to work their scheduled shift or visit will be reported in writing to the appropriate manager (Nurse Manager for Nurse shift coverage; Aide Manager for Aide shift coverage; Therapy Manager for Therapy shift coverage) inclusive of how the shift was eventually covered. These reports will be used to identify hiring needs and when the agency experiences shortages in staff that information will be given to referring sources noting the agency is unable to staff their needs which would preclude acceptance of the referral. Managers will report to Director/Administrator, these instances and subsequent hiring or needed staff. By 12/27/13 all staff involved in scheduling will</p> | 03/31/2014 | | | |

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| | <p>to call off." The record failed to evidence attempts for replacement of the service.</p> <p>B. On 11/21/13 at 1 PM, employee A indicated homemaker services were not provided to the patient for weeks 1 and 2 but the physician was notified. The employee was unable to provide documentation of attempts for replacement of the service.</p> <p>2. Agency policy with effective date of 7/92 and last revision date of 5/12 titled "Patient/Client care plan" states, "Objective: To have in effect, on a timely basis, a care plan based on both the initial and ongoing patient/client assessments, that is designed to: 1. Comply with the attending physician's orders ... "</p> | | <p>have been given this information and instructions to follow these procedures when faced with unstaffed periods of care. Diane Whitcomb, Director/Administrator will be responsible for assuring these measures are being followed.</p> | | |

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| N000524 | <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on clinical record and policy review, observation, and interview, the agency failed to ensure the plan of care included all the patient's equipment in 3 of 10 home visit observations with the potential to affect all the agency's patients. (#3, 8, and 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #3, start of care 11/1/13, included a plan of care for the | N000524 | All agency clinicians will be in-serviced to identify all equipment in the patient/client home that is being used by the patient or agency associates in provision of care. Once identified, all equipment will be entered in the 485 or added via a physician's interim order if found after SOC, Recertification, or Resumption of services and if patient/client is using the equipment. Clinicians performing SOC, Recertification, ROC visits will be required to check for | 03/31/2014 |
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| | <p>certification period 11/1 to 12/30/13 that failed to include all patient equipment.</p> <p>A. On 11/19/13 at 9 AM, a home visit was conducted at which time the patient was observed using a cane. The cane was not listed on the plan of care.</p> <p>B. On 11/20/13 at 1:25 PM, employee C indicated the cane was not listed on the plan of care.</p> <p>2. Clinical record #8, start of care 11/1/13, included a plan of care for the certification period 11/1 to 12/30/13 that failed to include all patient equipment.</p> <p>A. On 11/19/13 at 10:20 AM, a home visit was conducted at which time employee M (occupational therapist) was observed using a gait belt to assist patient with therapy exercises. The gait belt was not listed on the plan of care.</p> <p>B. On 11/20/13 at 1:27 PM, employee C indicated the gait belt was not listed on the plan of care.</p> <p>3. Clinical record #9, start of care 11/1/13, included a plan of care for the certification period 11/1 to 12/30/13 that failed to include all patient equipment.</p> <p>A. On 11/19/13 at 3:15 PM, a home</p> | | <p>equipment prior to locking the OASIS/485. QA Nurse will review all SOC, ROC, Recertifications to assure all equipment listed in referral information is also listed on the 485 or ROC orders. Therapy Managers will perform ongoing medical chart reviews now through March 31, 2014, sampling at least 20 charts per month to assure this standard is being met. The goal is to be 100% compliant. If by 3/31/14 this goal has not been met, review and monitoring will continue until the goal is met. This affected 3 current patients. Orders to add the assistive devices were received from their respective physicians and added to the POC via interim order. Therapists involved in the care in each of these cases instructed the patient on proper and safe use of the assistive device. Return demonstration was provided. This was achieved by the Therapy Manager and therapists as of 11/29/13. Diane Whitcomb, Director/Administrator will be responsible for seeing these procedures are followed and the goal is met.</p> | | |

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| | <p>visit was conducted at which time employee K (physical therapist) was observed using a gait belt to assist patient with therapy exercises. The gait belt was not listed on the plan of care.</p> <p>B. On 11/20/13 at 1:34 PM, employee C indicated the gait belt was not listed on the plan of care.</p> <p>4. The agency policy effective 12/93 with revision dates of 12/93, 3/94, 4/95, 11/95, 8/97, 12/98, 3/02, 1/03, 8/07, and 6/09 titled "Physician orders-plan of treatment" states, " Procedure: ... 2. The plan of treatment shall include, but not be limited to: ... O. equipment and supplies as needed."</p> | | | | |

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| N000608 | <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the clinical notes in the record were signed and dated in 1 of 20 records reviewed. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 11/1/13, contained a document titled "Medication Profile." The document failed to evidence signature and date of discipline completing the medication review.</p> <p>On 11/18/13 at 3:10 PM, employee A</p> | N000608 | At SOC all clinicians will be instructed to review documents to assure the medication record is signed and dated, either manually or electronically verified prior to locking the SOC, Recertification, and/or Resumption. Also, during QA review the QA nurse will check to make sure all medication records are signed or verified by the clinician who performed the visit. The QA Nurse and agency Managers will provide the instruction to all clinicians by 1/3/2014. Ongoing pre-billing and quality chart reviews will indicate 100% compliance with this plan of correction. This is and will continue to be a key quality and safety measure of the existing | 01/31/2014 | | | |

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| | <p>indicated the document should have been signed and dated by the personnel completing the review.</p> <p>2. The agency policy with an effective date of 3/29/93 and last revision date of 2/03 titled "Record entry authentication" states, "Policy: All entries into patient/client records shall be authenticated and dated and include title of person making entry."</p> | | <p>quarterly chart reviews. For purposes of measuring the effect of the plan of correction on this problem the agency will randomly review 20 medical records by 1/31/14 expecting 100% compliance. If this goal is not met 1:1 instruction will occur with any clinician who has not demonstrated understanding and compliance and monitoring of those clinicians' charts will continue until 100% compliance is met. In the case of the record found unsigned during the survey, it was corrected prior to the end of the survey, 11/21/13. Diane Whitcomb, Director/Administrator will be responsible for compliance with this plan of correction and ongoing monitoring.</p> | | |

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| N000614 | <p>410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service.</p> <p>Based on clinical record review and interview, the agency failed to ensure closed files did not become current service files for 2 of 20 clinical records reviewed. (#2 and 15)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 11/12/13, contained a physicians plan of care for certification period 11/12/13 to 1/2/14. The record included a date of referral as 11/11/13 with a comprehensive assessment dated 11/12/13.</p> <p>A. The record evidenced a physician's plan of care with a start of care as 7/7/13 for certification period 7/7/ to 9/4/13 and a document dated 8/13/13 titled "Notice</p> | N000614 | When an episode of care is completed and patient is discharged from all agency services the chart will be 'closed' in medical records. Should the same patient/client begin a new episode of care a new medical record chart will be started. Medical records staff will be instructed on this process. This will be monitored for 3 months to assure compliance. A sampling of 20 medical records per month will be done and results documented. Agency will achieve 100% compliance or monitoring/reviewing will continue until it is achieved. Chart reviews will be done by medical records staff and agency managers. Diane Whitcomb, Director/Administrator, and Jacqueline Kerwin, Director of Fianace, IS, and | 03/31/2014 | | | |

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| | <p>of Medicare provider non-coverage" that states, "The effective date coverage of your current home health services will end: 8/16/13."</p> <p>B. On 11/18/13 at 2:35 PM, employee A indicated the chart contained both current documentation and documentation of previous admissions for this patient. Employee A was unaware the chart contained past admission information because the closed records are kept separate.</p> <p>2. Clinical record #15, start of care 8/28/13, contained a physicians plan of care for certification period 10/27/13 to 12/25/14. The record included a document dated 11/12/13 titled "Comprehensive adult assessment" which states, "Start of Care Version."</p> <p>A. The record evidenced a physician's plan of care with a start of care as 10/23/12 for the certification period 8/19 to 10/17/13 and a document completed by the registered nurse dated 9/27/13 titled "Outcome and assessment information set ... Discharge from agency version."</p> <p>B. On 11/18/13 at 1:10 PM, employee A indicated the chart contained both current documentation and documentation of previous admissions for</p> | | Medical Records will be responsible for this plan and goal achievement. | | | | |

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| | this patient. | | | |