

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157619	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/14/2013
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NAME OF PROVIDER OR SUPPLIER CORNERSTONE HOME HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5 HIGH STREET MOORESVILLE, IN 46158
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G000000	<p>This visit was a home health agency federal certification survey. This was an extended survey.</p> <p>Survey dates: June 10, 11, 12, and 13</p> <p>Facility #: 12076</p> <p>Medicaid Vendor #: 200942300</p> <p>Surveyor: Marty Coons, RN, PH Nurse Surveyor</p> <p>Agency census 224</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 18, 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 and policy review, and interview, the agency failed to ensure verbal orders were obtained for therapy services by the registered nurse or qualified therapist in 4 of 6 clinical records reviewed of patients with occupational therapy services (# 1, 2, 3, and 4) and in 2 of 2 clinical records reviewed of patients with speech therapy services (# 2 and 3) creating the potential to affect all the patients of the agency that receive therapy services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The agency policy titled "Plan of Care Development and Review, Reference # 801.90" states, "The ... or Licensed Therapist develop a plan of care within 24 hours of completion of the start of care. The plan of care is reviewed, updated and/or modified as necessary. The attending physician is alerted to any changes that suggest a need to alter the plan of care." Clinical record #1, start of care (SOC) 	G000158	<p>Administrator and Director of Client Care Services reviewed and amended Policy and Procedure 801.90 Plan of Care Development and Review. The policy was amended to include: 1. clinical staff responsibilities initiating process to obtain verbal orders for treatment from ordering physician on the day of the initial evaluation; 2. The communication of obtained verbal orders between all skilled staff involved in the development of the plan of care; 3. The completion of a start of care order, including frequency and duration of all involved disciplines based on the verbal orders received from the physician. Amended on 06/19/2013</p> <p>Administrator and Director of Client Care Services reviewed and amended Policy and Procedure 500.30 Confirmation Of Physician Telephone/Verbal Orders. The policy was amended to that verbal/telephone orders may initial be transcribed onto the Initial Evaluation/Treatment Form. Amended on 06/19/2013.</p>	07/01/2013
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	<p>5-30-13, included an established plan of care (POC), for the certification period dated 5-30-13 through 7-28-13 that identified the patient was to receive Occupational Therapy (OT) services 1 time a week for 1 week and then 2 times a week for 4 weeks effective on 6-1-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>A. The record evidenced the patient received an OT evaluation on 6-1-13 and OT services on 6-4-13 and 6-6-13.</p> <p>B. On 6-13-13 at 5:20 PM, the administrator indicated there was an order for the OT to evaluate the patient but no updated verbal physicians order for OT's actual treatment of the patient once the evaluation was completed outlining the treatment to be provided and the frequencies of the OT visits.</p> <p>3. Clinical record # 2, SOC 5-30-13, included an established POC for the certification period dated 5-30-13 through 7-28-13 that identified the patient was to receive OT services 1 time a week for 1 week and then 2 times a week for 3 weeks effective on 6-1-13 and speech therapy</p>		<p>Administrator and Director of Client Care Services reviewed and amended Skilled Nursing Initial Assessment, Physical Therapy Evaluation/Treatment form, Occupational Therapy Evaluation/Treatment form and Speech Therapy Evaluation/Treatment form. All forms were amended to include notation of date verbal order was received and from whom they were received. Completed on 06/14/2013</p> <p>Director of Client Care Services created new Start Of Care order form on 06/19/2013.</p> <p>Director of Client Care services will in service all clinical staff on new Policy and Procedures 801.90 and 500.30, utilization of Start Of Care order form and utilization of new Evaluation/Treatment forms as well as each clinicians responsibility in obtaining and documenting receipt of verbal orders. All staff to be in serviced by 06/28/2013</p> <p>All amended Policy and Procedures, Evaluation and Treatment forms and</p>		

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	<p>services 1 time a week for 4 weeks effective on 6-5-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>A. The record evidenced the patient received an OT evaluation on 6-1-13 and OT services on 6-5-13 and 6-8-13</p> <p>B. The record evidenced speech therapy services were provided on 6-5-13 and 6-11-13.</p> <p>4. Clinical record # 3, SOC 6-4-13, included an established POC for the certification period dated 6-4-13 through 8-22-13 that identified the patient was to receive OT services 2 times a week for 3 week effective on 6-5-13 and speech therapy services 1 time a week for 4 weeks effective on 6-5-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>A. The record evidenced the patient received an OT evaluation on 6-4-13 and OT services on 6-5-13, 6-8-13, and 6-11-13.</p>		<p>Start of Care order forms to be initialed beginning week of 06/30/2013.</p> <p>Director of Client Care Services will perform ongoing monitoring for documentation of verbal orders on initial evaluations/treatment forms and Start Of Care order forms, as well as, interim orders to ensure all staff members are obtaining and documenting the receipt of verbal orders for initiation of services and treatment, as well as, change in frequency. Any staff member not adhering to policy will undergo remediation training.</p>		

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	<p>B. The record also evidenced speech therapy evaluation on 6-5-13.</p> <p>5. Clinical record # 4, SOC 4-18-13, included an established POC for the certification period dated 4-18-13 through 6-13-13 that identified the patient was to receive OT services 1 time a week for 1 week and then 3 times a week for 2 weeks, then 2 times a week times 2 weeks then 1 time a week for 1 week effective on 4-19-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>The record evidenced the patient received an OT evaluation on 4-19-13 and OT services on 4-22-13, 4-24-13, 4-26-13, 4-30-13, 5-1-13, 5-2-13, 5-6-13, 5-9-13, 5-13-13-, 5-17-13 and 5-20-13. Then a physician order was received for OT services on 5-20-13 revising the type of service the OT was to perform and the frequency of OT visits.</p>				

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G000162	<p>484.18(a) PLAN OF CARE The therapist and other agency personnel participate in developing the plan of care.</p> <p>Based on clinical record and policy review, and interview, the agency failed to ensure verbal orders were obtained for therapy services by the registered nurse or qualified therapist in 4 of 6 clinical records reviewed of patients with occupational therapy services (# 1, 2, 3, and 4) and in 2 of 2 clinical records reviewed of patients with speech therapy services (# 2 and 3) creating the potential to affect all the patients of the agency that receive therapy services.</p> <p>Findings include:</p> <p>1. The agency policy titled "Plan of Care Development and Review, Reference # 801.90" states, "The ... or Licensed Therapist develop a plan of care within 24 hours of completion of the start of care. The plan of care is reviewed, updated and/or modified as necessary. The attending physician is alerted to any changes that suggest a need to alter the plan of care."</p> <p>2. Clinical record #1, start of care (SOC) 5-30-13, included an established plan of care (POC), for the certification period dated 5-30-13 through 7-28-13 that</p>	G000162	<p>Administrator and Director of Client Care Services reviewed and amended Policy and Procedure 801.90 Plan of Care Development and Review. The policy was amended to include: 1. clinical staff responsibilities initiating process to obtain verbal orders for treatment from ordering physician on the day of the initial evaluation; 2. The communication of obtained verbal orders between all skilled staff involved in the development of the plan of care; 3. The completion of a start of care order, including frequency and duration of all involved disciplines based on the verbal orders received from the physician. Amended on 06/19/2013</p> <p>Administrator and Director of Client Care Services reviewed and amended Policy and Procedure 500.30 Confirmation Of Physician Telephone/Verbal Orders. The policy was amended to that verbal/telephone orders may initial be transcribed onto the Initial Evaluation/Treatment Form. Amended on 06/19/2013.</p>	07/01/2013	

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	<p>identified the patient was to receive Occupational Therapy (OT) services 1 time a week for 1 week and then 2 times a week for 4 weeks effective on 6-1-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>A. The record evidenced the patient received an OT evaluation on 6-1-13 and OT services on 6-4-13 and 6-6-13.</p> <p>B. On 6-13-13 at 5:20 PM, the administrator indicated there was an order for the OT to evaluate the patient but no updated verbal physicians order for OT's actual treatment of the patient once the evaluation was completed outlining the treatment to be provided and the frequencies of the OT visits.</p> <p>3. Clinical record # 2, SOC 5-30-13, included an established POC for the certification period dated 5-30-13 through 7-28-13 that identified the patient was to receive OT services 1 time a week for 1 week and then 2 times a week for 3 weeks effective on 6-1-13 and speech therapy services 1 time a week for 4 weeks effective on 6-5-13. The orders for the therapy services were added to the plan of</p>		<p>Administrator and Director of Client Care Services reviewed and amended Skilled Nursing Initial Assessment, Physical Therapy Evaluation/Treatment form, Occupational Therapy Evaluation/Treatment form and Speech Therapy Evaluation/Treatment form. All forms were amended to include notation of date verbal order was received and from whom they were received. Completed on 06/14/2013</p> <p>Director of Client Care Services created new Start Of Care order form on 06/19/2013.</p> <p>Director of Client Care services will in service all clinical staff on new Policy and Procedures 801.90 and 500.30, utilization of Start Of Care order form and utilization of new Evaluation/Treatment forms as well as each clinicians responsibility in obtaining and documenting receipt of verbal orders. All staff to be in serviced by 06/28/2013</p> <p>All amended Policy and Procedures, Evaluation and Treatment forms and Start of Care order forms to be initialed beginning week of 06/30/2013.</p>				

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	<p>care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>A. The record evidenced the patient received an OT evaluation on 6-1-13 and OT services on 6-5-13 and 6-8-13</p> <p>B. The record evidenced speech therapy services were provided on 6-5-13 and 6-11-13.</p> <p>4. Clinical record # 3, SOC 6-4-13, included an established POC for the certification period dated 6-4-13 through 8-22-13 that identified the patient was to receive OT services 2 times a week for 3 week effective on 6-5-13 and speech therapy services 1 time a week for 4 weeks effective on 6-5-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>A. The record evidenced the patient received an OT evaluation on 6-4-13 and OT services on 6-5-13, 6-8-13, and 6-11-13.</p> <p>B. The record also evidenced speech therapy evaluation on 6-5-13.</p>		<p>Director of Client Care Services will perform ongoing monitoring for documentation of verbal orders on initial evaluations/treatment forms and Start Of Care order forms, as well as, interim orders to ensure all staff members are obtaining and documenting the receipt of verbal orders for initiation of services and treatment, as well as, change in frequency. Any staff member not adhering to policy will undergo remediation training.</p>	

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	<p>5. Clinical record # 4, SOC 4-18-13, included an established POC for the certification period dated 4-18-13 through 6-13-13 that identified the patient was to receive OT services 1 time a week for 1 week and then 3 times a week for 2 weeks, then 2 times a week times 2 weeks then 1 time a week for 1 week effective on 4-19-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>The record evidenced the patient received an OT evaluation on 4-19-13 and OT services on 4-22-13, 4-24-13, 4-26-13, 4-30-13, 5-1-13, 5-2-13, 5-6-13, 5-9-13, 5-13-13-, 5-17-13 and 5-20-13. Then a physician order was received for OT services on 5-20-13 revising the type of service the OT was to perform and the frequency of OT visits.</p>				

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N000000	<p>This visit was a home health agency state licensure survey.</p> <p>Survey dates: June, 10, 11, 12, and 13 2013</p> <p>Facility #: 12076</p> <p>Medicaid Vendor #: 200942300</p> <p>Surveyor: Marty Coons, RN, PH Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 18, 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 and policy review, and interview, the agency failed to ensure verbal orders were obtained for therapy services by the registered nurse or qualified therapist in 4 of 6 clinical records reviewed of patients with occupational therapy services (# 1, 2, 3, and 4) and in 2 of 2 clinical records reviewed of patients with speech therapy services (# 2 and 3) creating the potential to affect all the patients of the agency that receive therapy services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The agency policy titled "Plan of Care Development and Review, Reference # 801.90" states, "The ... or Licensed Therapist develop a plan of care within 24 hours of completion of the start of care. The plan of care is reviewed, updated and/or modified as necessary. The attending physician is alerted to any changes that suggest a need to alter the plan of care." Clinical record #1, start of care (SOC) 5-30-13, included an established plan of 	N000522	<p>Administrator and Director of Client Care Services reviewed and amended Policy and Procedure 801.90 Plan of Care Development and Review. The policy was amended to include: 1. clinical staff responsibilities initiating process to obtain verbal orders for treatment from ordering physician on the day of the initial evaluation; 2. The communication of obtained verbal orders between all skilled staff involved in the development of the plan of care; 3. The completion of a start of care order, including frequency and duration of all involved disciplines based on the verbal orders received from the physician. Amended on 06/19/2013</p> <p>Administrator and Director of Client Care Services reviewed and amended Policy and Procedure 500.30 Confirmation Of Physician Telephone/Verbal Orders. The policy was amended to that verbal/telephone orders may initial be transcribed onto the Initial Evaluation/Treatment Form. Amended on 06/19/2013.</p>	07/01/2013			

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	<p>care (POC), for the certification period dated 5-30-13 through 7-28-13 that identified the patient was to receive Occupational Therapy (OT) services 1 time a week for 1 week and then 2 times a week for 4 weeks effective on 6-1-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>A. The record evidenced the patient received an OT evaluation on 6-1-13 and OT services on 6-4-13 and 6-6-13.</p> <p>B. On 6-13-13 at 5:20 PM, the administrator indicated there was an order for the OT to evaluate the patient but no updated verbal physicians order for OT's actual treatment of the patient once the evaluation was completed outlining the treatment to be provided and the frequencies of the OT visits.</p> <p>3. Clinical record # 2, SOC 5-30-13, included an established POC for the certification period dated 5-30-13 through 7-28-13 that identified the patient was to receive OT services 1 time a week for 1 week and then 2 times a week for 3 weeks effective on 6-1-13 and speech therapy services 1 time a week for 4 weeks</p>		<p>Administrator and Director of Client Care Services reviewed and amended Skilled Nursing Initial Assessment, Physical Therapy Evaluation/Treatment form, Occupational Therapy Evaluation/Treatment form and Speech Therapy Evaluation/Treatment form. All forms were amended to include notation of date verbal order was received and from whom they were received. Completed on 06/14/2013</p> <p>Director of Client Care Services created new Start Of Care order form on 06/19/2013.</p> <p>Director of Client Care services will in service all clinical staff on new Policy and Procedures 801.90 and 500.30, utilization of Start Of Care order form and utilization of new Evaluation/Treatment forms as well as each clinicians responsibility in obtaining and documenting receipt of verbal orders. All staff to be in serviced by 06/28/2013</p> <p>All amended Policy and Procedures, Evaluation and Treatment forms and</p>				

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	<p>effective on 6-5-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>A. The record evidenced the patient received an OT evaluation on 6-1-13 and OT services on 6-5-13 and 6-8-13</p> <p>B. The record evidenced speech therapy services were provided on 6-5-13 and 6-11-13.</p> <p>4. Clinical record # 3, SOC 6-4-13, included an established POC for the certification period dated 6-4-13 through 8-22-13 that identified the patient was to receive OT services 2 times a week for 3 week effective on 6-5-13 and speech therapy services 1 time a week for 4 weeks effective on 6-5-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>A. The record evidenced the patient received an OT evaluation on 6-4-13 and OT services on 6-5-13, 6-8-13, and 6-11-13.</p>		<p>Start of Care order forms to be initialed beginning week of 06/30/2013.</p> <p>Director of Client Care Services will perform ongoing monitoring for documentation of verbal orders on initial evaluations/treatment forms and Start Of Care order forms, as well as, interim orders to ensure all staff members are obtaining and documenting the receipt of verbal orders for initiation of services and treatment, as well as, change in frequency. Any staff member not adhering to policy will undergo remediation training.</p>		

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	<p>B. The record also evidenced speech therapy evaluation on 6-5-13.</p> <p>5. Clinical record # 4, SOC 4-18-13, included an established POC for the certification period dated 4-18-13 through 6-13-13 that identified the patient was to receive OT services 1 time a week for 1 week and then 3 times a week for 2 weeks, then 2 times a week times 2 weeks then 1 time a week for 1 week effective on 4-19-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>The record evidenced the patient received an OT evaluation on 4-19-13 and OT services on 4-22-13, 4-24-13, 4-26-13, 4-30-13, 5-1-13, 5-2-13, 5-6-13, 5-9-13, 5-13-13-, 5-17-13 and 5-20-13. Then a physician order was received for OT services on 5-20-13 revising the type of service the OT was to perform and the frequency of OT visits.</p>				

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N000565	<p>410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary);</p> <p>Based on clinical record and policy review, and interview, the agency failed to ensure verbal orders were obtained for therapy services by the registered nurse or qualified therapist in 4 of 6 clinical records reviewed of patients with occupational therapy services (# 1, 2, 3, and 4) and in 2 of 2 clinical records reviewed of patients with speech therapy services (# 2 and 3) creating the potential to affect all the patients of the agency that receive therapy services.</p> <p>Findings include:</p> <p>1. The agency policy titled "Plan of Care Development and Review, Reference # 801.90" states, "The ... or Licensed Therapist develop a plan of care within 24 hours of completion of the start of care. The plan of care is reviewed, updated and/or modified as necessary. The attending physician is alerted to any changes that suggest a need to alter the plan of care."</p> <p>2. Clinical record #1, start of care (SOC) 5-30-13, included an established plan of</p>	N000565	<p>Administrator and Director of Client Care Services reviewed and amended Policy and Procedure 801.90 Plan of Care Development and Review. The policy was amended to include: 1. clinical staff responsibilities initiating process to obtain verbal orders for treatment from ordering physician on the day of the initial evaluation; 2. The communication of obtained verbal orders between all skilled staff involved in the development of the plan of care; 3. The completion of a start of care order, including frequency and duration of all involved disciplines based on the verbal orders received from the physician. Amended on 06/19/2013</p> <p>Administrator and Director of Client Care Services reviewed and amended Policy and Procedure 500.30 Confirmation Of Physician Telephone/Verbal Orders. The policy was amended to that verbal/telephone orders may initial be transcribed onto the Initial Evaluation/Treatment Form. Amended on 06/19/2013.</p>	07/01/2013	

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	<p>care (POC), for the certification period dated 5-30-13 through 7-28-13 that identified the patient was to receive Occupational Therapy (OT) services 1 time a week for 1 week and then 2 times a week for 4 weeks effective on 6-1-13. The orders for the therapy services were added to the plan of care after the verbal order for the plan of care was received. The record failed to evidence a physician verbal order for OT and speech therapy services.</p> <p>A. The record evidenced the patient received an OT evaluation on 6-1-13 and OT services on 6-4-13 and 6-6-13.</p> <p>B. On 6-13-13 at 5:20 PM, the administrator indicated there was an order for the OT to evaluate the patient but no updated verbal physicians order for OT's actual treatment of the patient once the evaluation was completed outlining the treatment to be provided and the frequencies of the OT visits.</p> <p>3. Clinical record # 2, SOC 5-30-13, included an established POC for the certification period dated 5-30-13 through 7-28-13 that identified the patient was to receive OT services 1 time a week for 1 week and then 2 times a week for 3 weeks effective on 6-1-13 and speech therapy services 1 time a week for 4 weeks</p>		<p>Administrator and Director of Client Care Services reviewed and amended Skilled Nursing Initial Assessment, Physical Therapy Evaluation/Treatment form, Occupational Therapy Evaluation/Treatment form and Speech Therapy Evaluation/Treatment form. All forms were amended to include notation of date verbal order was received and from whom they were received. Completed on 06/14/2013</p> <p>Director of Client Care Services created new Start Of Care order form on 06/19/2013.</p> <p>Director of Client Care services will in service all clinical staff on new Policy and Procedures 801.90 and 500.30, utilization of Start Of Care order form and utilization of new Evaluation/Treatment forms as well as each clinicians responsibility in obtaining and documenting receipt of verbal orders. All staff to be in serviced by 06/28/2013</p> <p>All amended Policy and Procedures, Evaluation and Treatment forms and Start of Care order forms to be</p>		

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