

10A NCAC 13J .1202 CASE REVIEW AND PLAN OF CARE

(a) The plan of care shall be established in collaboration with the client and incorporated in the service record. The plan of care shall be reviewed every 90 days by the health care practitioner and revised as needed based on the client's needs. If the client record is purged, the original and updated authorization or orders for care shall be maintained in the client's record. All records shall be available to Department staff for review if requested. If physician orders are needed for the services, the health care practitioner shall notify the physician of any changes in the client's condition that indicates the need for altering the plan of care or for terminating services. Based upon the findings of the client assessment, the plan of care shall include the following:

- (1) type of service(s) and care to be delivered;
- (2) frequency and duration of service;
- (3) activity restrictions;
- (4) safety measures; and
- (5) service objectives and goals.

(b) Where applicable, the plan of care shall include:

- (1) equipment required;
- (2) functional limitations;
- (3) rehabilitation potential;
- (4) diet and nutritional needs;
- (5) medications and treatments;
- (6) specific therapies;
- (7) pertinent diagnoses; and
- (8) prognosis.

(c) If the health care practitioner is assigned responsibility for two or more of the following, these functions may be conducted during the same home visit:

- (1) assessment of client's condition, progress, and response every 90 days;
- (2) provision of regularly scheduled professional services; or
- (3) supervision of in-home caregiver.

*History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
Amended Eff. May 1, 1993;
RRC Objection due to lack of statutory authority Eff. November 16, 1995;
Amended Eff. February 1, 1996;
Readopted Eff. June 1, 2018.*