



Presenter



Customer Success Manager

Lynne Ingraham

✉ lynne@homecaresoftware



The Plan of Care (POC)

Customizing, Attaching, Viewing, Signing

What's Available in Generations?

485 Start*	Care Plan*	CMS 487*	Diagnosis*	DME/Safety/Nutritional/Allergies*	Goals*
Limitations/Activities/Mental Status/Progress*	Medications*	Orders*	Physicians*	Special Instructions	Tasks

Care Plan/Assessment (default)

This is a very basic care plan/assessment template that includes client information, along with ability to identify areas in categories such as bathing, oral care, dressing, housekeeping where assistance may be needed. It can be augmented with additional information regarding Tasks, Medications, Limitations, DME, Allergies, etc if desired.

Care Plan/Assessment (customized)

Customize the care plan tab of the POC to include those items YOU wish to assess on.

CMS485/CMS487

This standardized form from the Dept of Health & Human Services can be generated by completing the appropriate POC tabs. (Not customizable.)

POC Attachments

If customizing the Generations Care Plan doesn't quite fit the bill, you can attach your own, fully custom POC via Care Plan Attachments.

Benefits...

A care plan is simply a document where the needs, strengths, preferences, and environment of the client can be assessed and documented, as well as an outline for the level of support that will be provided.

- Paperless
- Shareable
- Easily updated for re-assessments
- History retained
- Customizable
- Use Multiple Templates
- Electronic Signatures (Care Plan Only)

Today's Agenda

- **CMS 485 / CMS 487**
- **Default “Original” Care Plan**
- **Customizing**
- **Completing**
- **Care Plan Attachments**
- **Printing**
- **Sharing**
- **Associated Reports & Dashboard**
- **Best Practices**
- **Need additional help?**

The Generations Plan of Care

Within each client's record, you'll find a Plan of Care tab.

Information Summary Audit Outlook Email Calendar Close

Client: DoRight, Dudley

Personal Data	Attachments	Charting	Contacts	Custom Fields	Directions/Misc	Exclusions/Preferences	History	Interruptions of Service
Needs	Notes	Plan Of Care (485)	Reminders	Service Orders	Supervisory Visits	Visit History	Wellness	

First Name: Dudley Middle Initial: T Last Name: DoRight
Phone 1: 879-213-2196 Phone 2: Date of Birth: 07/15/1952 68



Personal Data	Attachments	Charting	Contacts	Custom Fields	Directions/Misc	Exclusions/Preferences	History	Interruptions of Service
Needs	Notes	Plan Of Care (485)	Reminders	Service Orders	Supervisory Visits	Visit History	Wellness	

Column Chooser 0 to 0 of 0 Records

+ New	Attachment	Plan Type	Assessed Date	Assessment Revised	Authorized Start Date	Authorized End Date	Name	Start Care Date
Sorry, no records found								

If the client does not have a care plan set up, the screen will look like this.

The Generations Plan of Care

These are the areas in which you can enter assessment data that will feed both the Care Plan Report as well as the CMS485/CMS487.

Let's quickly go thru them tab-by-tab.

The screenshot displays a web interface for the CMS 485 Report. At the top, there are four blue buttons: "CMS 485 Report", "Care Plan Report", "Print Assessment Form", and "Close POC". Below these buttons, the client name "Client: DoRight, Dudley" is displayed. The main content area is divided into several tabs: "485 Start*", "Care Plan", "CMS-487*", "Diagnosis*", "DME/Safety/Nutritional/Allergies*", and "Goals*". The "485 Start*" tab is currently selected. Below the tabs, there are several input fields and sections:

- 1. Name**: An empty text input field.
- 2. Patient's HI Claim No**: An empty text input field.
- 3. Start Care Date**: A date picker showing a date range from 08/25/2020 to 10/23/2020.
- 4. Certification Period**: A date picker showing a date range from 08/25/2020 to 10/23/2020.
- 5. Medical Record No.**: A greyed-out text input field.
- 6. Provider No.**: A text input field containing the value "test145".
- 7. Patient's Name and Address**: A greyed-out section.
- 8. Provider's Name, Address and Telephone Number**: A greyed-out section.

Other tabs visible include "Limitations/Activities/Mental Status/Prognosis*", "Medications*", "Orders*", "Physicians*", "Special Instructions", and "Tasks".

The Generations Plan of Care

485 Start

The majority of these fields represent specific fields on the CMS 485, and only need to be completed if you are generating that report.

If you are doing a Care Plan report:

Name: if you attached your own PDF or Word care plan, you'll see the document name here.
(Otherwise you can leave this field blank.)

Start Care Date: this field goes to both the CMS 485 as well as the Care Plan Report.

Certification Period: Enter here the range of dates covered by this data. (This will not print on the Care Plan report, but those dates are used to determine most current viewable by caregivers/clients.)

The remainder of the data only feeds the CMS 485.

Client: Fudd, Elmer

485 Start*	Care Plan	CMS-487*	Diagnosis*	DIME/Safety/Nutritional/Allergies*	Goals*
Limitations/Activities/Mental Status/Prognosis*	Medications*	Orders*	Physicians*	Special Instructions	Tasks

1. Name:

2. Patient's HI Claim No:

3. Start Care Date:

4. Certification Period: 08/31/2020 - 10/29/2020

5. Medical Record No.: 13546867

6. Provider No.: 88888888

7. Patient's Name and Address: Fudd Elmer
2625 Denison
MC Pleasant
MI 48858

8. Provider's Name, Address and Telephone Number: The GenSuccess Agency
23 S. Main Street
Miami, FL 33186
Phone: 965-450000

9. Date of Birth: 01/14/1937

10. Sex: Male Female

Notes: Medical record number, date of birth, and sex are displayed based on the values in the client intake form.
*Provider No. is displayed based on the provider number in company settings.
†Tabs with an asterisk contain fields that correspond to the CMS-485. Numbered fields correspond to the 485 fields.

The Generations Plan of Care

Client: Fudd, Elmer

485 Start*	Core Plan	CMS-487*	Diagnosis*	DME/Safety/Nutritional/Allergies*	Goals*
Limitations/Activities/Mental Status/Prognosis*	Medications*	Orders*	Physicians*	Special Instructions	Tasks

Enter any information here that will not fit on the 485. It is not necessary to enter medications and orders here as they will automatically be moved to the 487 page of the report if necessary.

Save

The CMS 487 is an addendum page to the CMS 485. Any information you enter for fields on the CMS 485 that will not fit will automatically flow over to the CMS 487.

If you do wish to enter directly onto the 487, the verbiage entered will appear on the CMS 487 (Addendum) in the "Other" field.

CMS-487

Department of Health and Human Services
 Centers for Medicare & Medicaid Services

Form Approved
 CMS No. 0930-0287

ADDENDUM : TO PLAN OF TREATMENT

1. Patient's Claim No. T01190750117101000	2. Start of Care Date 10/01/2006	3. Certification Period From: 08/01/2006 To: 09/30/2006	4. Medicare Account No. 03648887	5. Provider No. 22000000
6. Patient's Name and Address Elmer T. Fudd 1624 Serrano St. - Sacramento CA 95820			7. Provider's Name, Address and Telephone Number Dr. Scott Gordon Agency 10 E. Main Street Haltersville PA 17033	
8. Item No.				
Additional Meds				
Drug	Dose	Frequency	Route	NDC
DME and Supplies				
Safety Measures				
Nutritional Reg				
Allergies				
Functional Limitations				
Activities Permitted				
Special Notes				
Additional Notes				
Goals/Outcomes/Action/Prognosis/Change Plans				
Other DCA was entered directly on the CMS 487.				
9. Signature of Physician				10. Date
11. Optional Name/Signature of Nurse/Therapist				12. Date

Form CMS-487 (04/01/07)

The Generations Plan of Care

Diagnosis*

The CMS 485 has fields for multiple diagnoses. If CMS 485 is required, you'll enter here the diagnosis codes that need to be reported on this form.

Use the magnifying glass to search for & select the appropriate diagnosis code from the ICD10's.

(If by chance you're seeing ICD9's here, update the default code set in the CMS1500 Billing Defaults area in Company Settings.)

Client: Fudd, Elmer

485 Start* Care Plan CMS 487* **Diagnosis*** DME/Safety/Nutritional/Allergies* Goals*

Limitations/Activities/Mental Status/Prognosis* Medications* Orders* Physicians* Special Instructions* Tasks

Diagnosis from Client Intake: Age-related osteoporosis with current pathological fracture, left femur, subsequent encounter for fracture with malunion

Used for the CMS-485 report only. The diagnosis from the client intake form prints on the Care Plan Report.

11. Diagnosis Code	Principal Diagnosis	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
12. Diagnosis Code	Surgical Procedure	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
13. Diagnosis Code	Other Pertinent Diagnosis	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Save

CMS 1500 Billing Defaults

LINE 1 INSURANCE TYPE	Lowe Bank
LINE 1a (Insured's ID No.)	Medical Record #
LINE 6 PATIENT RELATIONSHIP TO INSURED	SELF
LINE 9a OTHER INSURED POLICY NUMBER	Medical Record Number
	Other
LINE 11 INSURED GRP NAME/FECA No.	
LINE 12 SIGNATURE - CHECK TO PRINT "Signature on File"	
LINE 17 REFERRAL SOURCE Field	Low Bank
LINE 19 RESERVED FOR LOCAL USE	
LINE 21 DEFAULT DIAGNOSIS CODE SET	<input type="radio"/> ICD9 <input checked="" type="radio"/> ICD10
LINE 23 PRIOR AUTH NUMBER	Low Bank

Lookup Diagnosis By Code or Description

Code Set: ICD-9 ICD-10

Search By: Code Description

Description Search Option: Begin With Contain

Add New

Code Search:

Code Version: 2019

Search Text:

Search

Close

The Generations Plan of Care

DME/Safety/Nutritional/Allergies*

Data entered here is for the corresponding fields of the CMS 485.

Should you wish the data you enter here to ALSO appear on the Care Plan report - just put a checkmark in the box.

These are free-form text boxes.

Client: Fudd, Elmer

485 Start*	Care Plan	CMS-487*	Diagnosis*	DME/Safety/Nutritional/Allergies*	Goals*
Limitations/Activities/Mental Status/Prognosis*	Medications*	Orders*	Physicians*	Special Instructions	Tasks

This information prints on both the CMS-485 and Care Plan Report. The numbers correspond to numbered fields on the CMS-485.

Print on the Care Plan Report

14. DME and Supplies:

15. Safety Measures:

16. Nutritional Req:

17. Allergies:

Save

The Generations Plan of Care

Goals*

Data entered here is for the corresponding fields of the CMS 485.

Free-form text

Client: Fudd, Elmer

485 Start*	Care Plan	CMS 487*	Diagnosis*	DME/Safety/Nutritional/Allergies*	Goals*
Limitations/Activities/Mental Status/Prognosis*	Medications*	Orders*	Physicians*	Special Instructions	Tasks

This information only appears on the CMS-485 report.
Goals/Rehabilitation Potential/Discharge Plans

[Save](#)

The Generations Plan of Care

Limitations/Activities/Mental Status/Prognosis*

Data entered here is for the corresponding fields of the CMS 485.

If you would like this information to also print on the Care Plan report, just place a checkmark in the box.

Client: Fudd, Elmer

485 Start*	Care Plan	CMS-487*	Diagnosis*	DME/Safety/Nutritional/Allergies*	Goals*
Limitations/Activities/Mental Status/Prognosis*	Medications*	Orders*	Physicians*	Special Instructions	Tasks

Prints on both the CMS-485 and Care Plan report. The numbers correspond to numbered fields on the CMS-485.

Print on the Care Plan Report

18.A. Functional Limitations

1	<input type="checkbox"/> Amputation	5	<input type="checkbox"/> Paralysis	9	<input type="checkbox"/> Legally Blind
2	<input type="checkbox"/> Incontinence	6	<input type="checkbox"/> Endurance	A	<input type="checkbox"/> Dyspnea
3	<input type="checkbox"/> Contracture	7	<input type="checkbox"/> Ambulation	B	<input type="checkbox"/> Other Limitation
4	<input type="checkbox"/> Hearing	8	<input type="checkbox"/> Speech		Descr: <input type="text"/>

18.B. Activities Permitted

1	<input type="checkbox"/> Complete Bed Rest	6	<input type="checkbox"/> Partial Weight Bearing	A	<input type="checkbox"/> Wheelchair
2	<input type="checkbox"/> Bed rest BRP	7	<input type="checkbox"/> Independent At Home	B	<input type="checkbox"/> Walker
3	<input type="checkbox"/> Up As Tolerated	8	<input type="checkbox"/> Crutches	C	<input type="checkbox"/> No Restrictions
4	<input type="checkbox"/> Transfer Bed/Chair	9	<input type="checkbox"/> Cane	D	<input type="checkbox"/> Other (Specify)
5	<input type="checkbox"/> Exercises Prescribed				Descr: <input type="text"/>

19. Mental Status:

1	<input type="checkbox"/> Oriented	3	<input type="checkbox"/> Forgetful	5	<input type="checkbox"/> Disoriented	7	<input type="checkbox"/> Agitated	9	<input type="checkbox"/> Dementia
2	<input type="checkbox"/> Comatose	4	<input type="checkbox"/> Depressed	6	<input type="checkbox"/> Lethargic	8	<input type="checkbox"/> Alzheimer's	10	<input type="checkbox"/> Other
									Descr: <input type="text"/>

20. Prognosis: Poor Guarded Fair Good Excellent

Save

The Generations Plan of Care

Medications*

Data entered here is for the corresponding fields of the CMS 485.

If you would like this information to also print on the Care Plan report, just place a checkmark in the box.

Client: Fudd, Elmer

485 Start*	Care Plan	CMS-487*	Diagnosis*	DME/Safety/Nutritional/Allergies*	Goals*
Limitations/Activities/Mental Status/Prognosis*	Medications*	Orders*	Physicians*	Special Instructions	Tasks

10. Medications Print Medications on Care Plan Report *Medication Always print on the CMS-485 Report

0 to 0 of 0 Records

+ New	Drug	Dose	Frequency	Route	Order Type	Start Date	DC Date	Sort Order
Sorry, no records found								

If you have many medications some may have carried over to the 487 Report. Medications are automatically carried over to the 487 Report

Drug	Dose	Frequency	Route	Reason
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Start Date	DC Date	Order Type	Sort Order	
<input type="text"/>	<input type="text"/>	--Select-- --Select-- New Changed Ongoing Continued Long Term Discontinued	<input type="text"/>	
Notes	<input type="text"/>			<input type="button" value="Save"/> <input type="button" value="Cancel"/>

If you have many medications some may have carried over to the 487 Report. Medications are automatically carried over to the 487 Report

Associated Reports

- Client Medications
- MAR

The Generations Plan of Care

Orders*

Data entered here is for the corresponding field of the CMS 485.



Client: Fudd, Elmer

485 Starc*	Care Plan	CM5-487*	Diagnosis*	DME/Safety/Nutritional/Allergies*	Goals*
Limitations/Activities/Mental Status/Prognosis*	Medications*	Orders*	Physicians*	Special Instructions	Tasks

Printed on the CMS-485 Report
21. Orders for Discipline and treatments (Specify Amount/Frequency/Duration)

0 to 0 of 0 Records

Discipline and Treatments Sort Order

—Select— 0

Notes

Save Cancel

Establish a master list of the disciplines and treatments you wish to document in field 21 of the CMS 485, then select them here, designate what order you wish them to appear in on the CMS 485, and add any additional notes desired.

The Generations Plan of Care

Physicians*

Data entered here is for the corresponding fields of the CMS 485.

Client: Fudd, Elmer

485 Start*	Care Plan	CMS-487*	Diagnosis*	DME/Safety/Nutritional/Allergies*	Goals*
Limitations/Activities/Mental Status/Prognosis*	Medications*	Orders*	Physicians*	Special Instructions	Tasks

This information prints on the CMS-485 report:

24. Physicians Name and Address

25. Date HHA Received Signed POT



Physicians in this dropdown are entered in your Physicians master list.

The Generations Plan of Care

Special Instructions

Documentation here only prints on the Care Plan report.

Client: Fudd, Elmer

485 Start*	Care Plan	CMS-487*	Diagnosis*	DME/Safety/Nutritional/Allergies*	Goals*
Limitations/Activities/Mental Status/Prognosis*	Medications*	Orders*	Physicians*	Special Instructions	Tasks

[Save](#)

Free-form text box.

The Generations Plan of Care

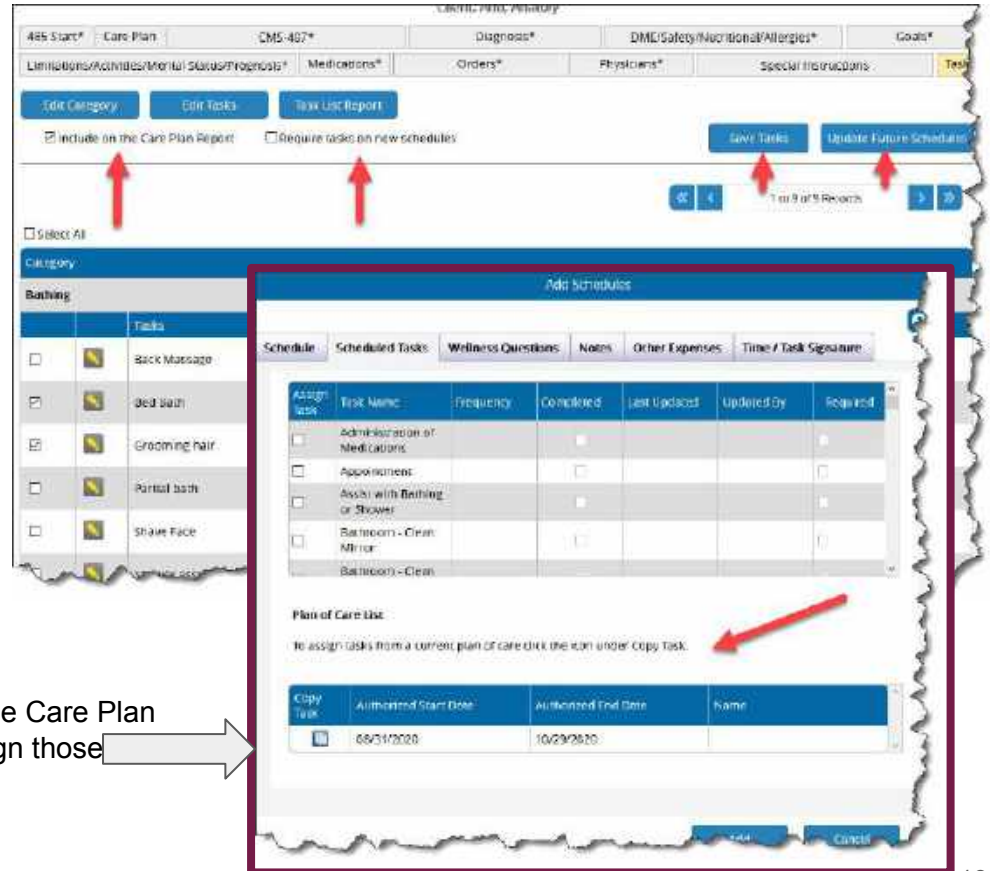
Tasks

Tasks can be included on the Care Plan report.



You can:

- Update the master list of tasks or task categories
- Elect to include the tasks on the Care Plan report
- Require tasks on all new schedules
- Update all future schedules with tasks selected here



The Task Category and Tasks master lists are customizable!

Setting up tasks on the Care Plan makes it easy to assign those tasks to schedules.

Care Plan Report

Client: DoRight, Dudley

Buttons: CMS 485 Report, Care Plan Report, Print Assessment Form, Close POC

485 Start* | Care Plan | CMS-487* | Diagnosis* | DME/Safety/Nutritional/Allergies+ | Goals* | Limitations/Activities/Mental Status/Prognosis* | Medications* | Orders* | Physicians+ | Special Instructions | Tasks

1. Name:

2. Patient's HI Claim No:

3. Start Care Date:

4. Certification Period: -

5. Medical Record No.:

6. Provider No.:

7. Patient's Name and Address:

8. Provider's Name, Address and Telephone Number:

The “Private Duty” Care Plan report is generated from the assessment data you enter on the Care Plan tab - and CAN include data from these other tabs:

- DME/Safety/Nutritional/Allergies
- Limitations/Activities/Mental Status/Prognosis
- Medications
- Tasks

As you can see on the next page - the default “Original” care plan template is simple and generic - and it may work PERFECTLY for you!

Care Plan Report

“Original” Template

Assessed By: Date:

Assessment Revision By: Date:

*Care plan date enters on the Care Plan report only

Mobility: Assist with ambulation Assist with transfers Bed/Chair only ROM exercises
 Something else:

Additional Information:

Other:

Toileting: Bathroom Bedpan Tissue Commode
 Depends

Additional Information:

Bathing: Partial Complete Tub Shower
 Sponge Bath Sink

Bathing Other:

Vision Loss: H Eye L Eye Peripheral only Wears glasses
 Contact lenses

Hearing: Hard of hearing Wears hearing aid Is Deaf

Diet: Normal Diabetic Low sodium Liquid only
 Assist with Meals Feeding Assistance

Diet:

Feeding Instructions:

Skin Care: Moisturizer Powder

Other:

Hair Care: Wash and dry Wash and set Comb and brush only

Oral Care: Brush and floss Denture care

Shaving: Shave face Shave axilla Shave legs Electric razor
 Safety razor

Nail Care: Clean File and trim Polish

Dressing: Self dress Help select clothes Assist with dressing

Weight: Weigh client

Frequency:

Shopping: Drives Self Caregiver may take out Call before taking out Waiver of liability on file
 Accompany on taxi/bus

Recreation: Outdoor recreation

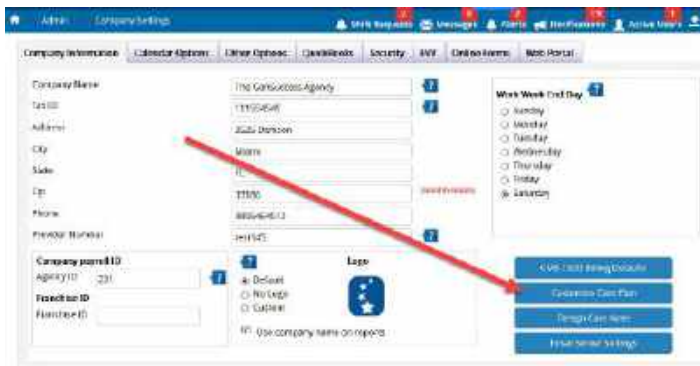
Guidelines:

Housekeeping: None Light Normal Heavy

Instructions:

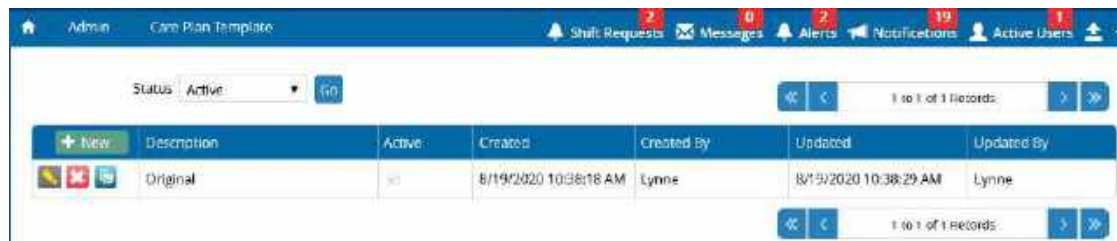
Save

Customizing the Care Plan tab of the POC



To custom fit that care plan tab to serve your purposes - go to Company Settings.

In the lower-right of the Company Information page you'll see Customize Care Plan.



Important things to know about customizing the Care Plan:

- You are not able to *delete* a care plan template if it is assigned to any client
- You not able to *modify* a care plan template that is established for any client if that care plan has been electronically signed.
- You can modify a template that is in use as long as they are NOT electronically signed. You will still receive a warning saying the # of clients it's assigned to - and advising that changing the template will alter the care plans assigned to those clients, as well.

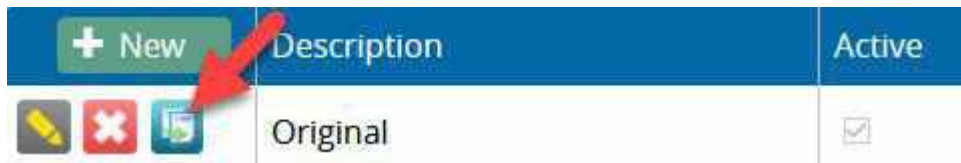
Customizing the Care Plan tab of the POC

Think about what you want that Care Plan area to look like.

If the “Original” one is close - but you’d like to add some things, delete other things - or maybe move things around - I recommend that you make a copy of that template - give the copy a new name, then make changes to it.

To make a copy of a template to work on - just click on the copy icon, enter a name of the new template, and click COPY.

Now - let’s get to work on customizing that new template.



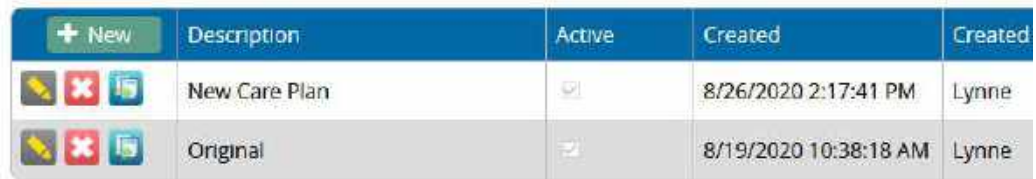
A screenshot of a table with a blue header and a white body. The header has three columns: '+ New', 'Description', and 'Active'. The first row has three icons (edit, delete, copy) in the first column, 'Original' in the second column, and a checked checkbox in the third column. A red arrow points to the copy icon.

+ New	Description	Active
	Original	<input checked="" type="checkbox"/>



A dialog box titled 'Copy Template' with a close button (X) in the top right. It contains a text input field with the text 'New Care Plan' and a blue 'Copy' button below it.

Status: Active









A screenshot of a table with a blue header and a white body. The header has five columns: '+ New', 'Description', 'Active', 'Created', and 'Created'. The first row has three icons, 'New Care Plan', a checked checkbox, '8/26/2020 2:17:41 PM', and 'Lynne'. The second row has three icons, 'Original', a checked checkbox, '8/19/2020 10:38:18 AM', and 'Lynne'.

+ New	Description	Active	Created	Created
	New Care Plan	<input checked="" type="checkbox"/>	8/26/2020 2:17:41 PM	Lynne
	Original	<input checked="" type="checkbox"/>	8/19/2020 10:38:18 AM	Lynne

Recommendation

Create a “dummy client” to test with if you will be customizing or creating a new care plan template.

Customizing the Care Plan tab of the POC

+ New	Description	Active	Created
  	New Care Plan	<input checked="" type="checkbox"/>	8/26
  	Original	<input type="checkbox"/>	8/19

















































































We begin by clicking on the pencil (edit) icon next to the template we wish to make changes to.

The template shows the main categories, how many questions & text boxes are in each category, what order they should appear in, etc.

Let's take a closer look at one Category on this template: **Mobility** - and we'll do that by clicking on the pencil icon for that category.

Care Plan Name Active

1 to 16 of 16 Records

+ New	Category	Active	Question Type	# Questions	# TextAreas	Sort Order	Sort
  	Mobility	<input checked="" type="checkbox"/>	Multi-Select	5	2	2	 
  	Toileting	<input type="checkbox"/>	Multi-Select	5	1	3	 
  	Bathing	<input checked="" type="checkbox"/>	Multi-Select	6	1	4	 
  	Vision Loss	<input type="checkbox"/>	Multi-Select	5	0	5	 
  	Hearing	<input checked="" type="checkbox"/>	Multi-Select	3	0	6	 
  	Diet	<input type="checkbox"/>	Multi-Select	6	2	7	 
  	Skin Care	<input checked="" type="checkbox"/>	Multi-Select	2	1	8	 
  	Hair Care	<input type="checkbox"/>	Multi-Select	3	0	9	 
  	Oral Care	<input checked="" type="checkbox"/>	Multi-Select	2	0	10	 
  	Shaving	<input type="checkbox"/>	Multi-Select	5	0	11	 
  	Nail Care	<input checked="" type="checkbox"/>	Multi-Select	3	0	12	 
  	Dressing	<input type="checkbox"/>	Multi-Select	3	0	13	 
  	Weight	<input checked="" type="checkbox"/>	Multi-Select	1	1	14	 
  	Shopping	<input type="checkbox"/>	Multi-Select	5	0	15	 
  	Recreation	<input checked="" type="checkbox"/>	Multi-Select	1	1	16	 
  	Housekeeping	<input type="checkbox"/>	Single-Select	4	1	17	 

Customizing the Care Plan tab of the POC

This opens up that item of the template. Let's go from top to bottom.

The screenshot shows the customization interface for a Care Plan. It includes the following sections:

- Category:** A text input field containing "Mobility".
- Status:** A dropdown menu currently set to "A".
- Question Type:** A radio button selection between "Single-Select Multiple Choice" and "Multi-Select Multiple Choice".
- Number of answer options:** A dropdown menu set to "5".
- Answer Options:** A list of five items: "1) Assist with ambulation", "2) Assist with transfers", "3) Bed/Chair only", "4) ROM Exercises", and "5) Something else". Each item has a red 'X' icon to its right.
- Text Questions:** A section with a "Number of Text Areas" dropdown set to "2" and a "Limit Answers to:" label.
- Text Question 1:** "1) Additional Information" with a red 'X' icon and a dropdown set to "1 line of text/ 100 Characters".
- Text Question 2:** "2) Other" with a red 'X' icon and a dropdown set to "3 lines of text/ 300 Characters".
- Buttons:** "Save" and "Cancel" buttons at the bottom.

The screenshot shows the Care Plan tab in a patient record. It includes the following sections:

- Assessment Fields:** "Assessed By:" and "Assessment Revision By:" with corresponding date pickers.
- Checkboxes:** "Assist with ambulation", "Assist with transfers", "Bed/Chair only", and "ROM Exercises".
- Additional Information:** A text input field.
- Other:** A text input field.
- Footer:** A note: "*Care plan data prints on the Care Plan report only."

- Category
- Status
- Question Type
 - Single select/multi select
 - Number of options (max 15)
- Text Questions (# of text boxes needed) (max 5)
- Labels for those text boxes
- Amt of space to provide in each text box

Customizing the Care Plan tab of the POC

Let's say I want to add change the checkbox options: I'll remove "Something Else!", and add "Wheelchair" and "Walker". Also - I really only need one text box, so I'll remove that "Other" field, and increase the space on the "Additional Information" text box. In the screen shot below - I've highlighted all of the areas I touched.

Category:

Status:

Question Type: Single-Select Multiple Choice Multi-Select Multiple Choice

Number of answer options:

- 1) Assist with ambulation
- 2) Assist with transfers
- 3) Bed/Chair only
- 4) ROM Exercises
- 5) Something else!

Text Questions

Number of Text Areas: Limit Answers to:

- 1) Additional Information
- 2) Other

Category:

Status:

Question Type: Single-Select Multiple Choice Multi-Select Multiple Choice

Number of answer options:

- 1) Assist with ambulation
- 2) Assist with transfers
- 3) Bed/Chair only
- 4) ROM Exercises
- 5) Wheelchair
- 6) Walker

Text Questions

Number of Text Areas: Limit Answers to:

- 1) Additional Information

Customizing the Care Plan tab of the POC

Category:

Status:

Question Type:
 Single-Select Multiple Choice Multi-Select Multiple Choice

Number of answer options:

- 1) Assist with ambulation
- 2) Assist with transfers
- 3) Bed/Chair only
- 4) ROM Exercises
- 5) Wheelchair
- 6) Walker

Text Questions

Number of Text Areas: Limit Answers to:

1) Additional Information

When I go to my 'dummy client', and create a new care plan using this template, I can see (under the Care Plan tab of the POC) that this area now looks like this:

Client: DoRight, Dudley

485 Start*	Care Plan	CMS-487*	Diagnosis*	DME/Safety/Nutritional/Allergies*	Goals*
Limitations/Activities/Mental Status/Prognosis*	Medications*	Orders*	Physicians*	Special Instructions	Tasks

Assessed By: Date:

Assessment Revision By: Date:

*Care plan data prints on the Care Plan report only.

Mobility:
















Assist with ambulation Assist with transfers Bed/Chair only ROM Exercises

Wheelchair Walker
















Additional Information

Customizing the Care Plan tab of the POC

Use the Sort up/down arrows to move categories to wherever you'd like them to appear on that Care Plan tab.

+ New	Category	Active	Question Type	# Questions	# TextAreas	Sort Order	Sort
  	Child/Parent	<input checked="" type="checkbox"/>	Single-Select	0	2	1	 
  	Psychosocial	<input checked="" type="checkbox"/>	Single-Select	0	5	2	 
  	Assessment Info	<input checked="" type="checkbox"/>	Single-Select	2	0	3	 

Remember to click SAVE after each change.

+ New	Category	Active	Question Type	# Questions	# TextAreas	Sort Order	Sort
  	Assessment Info	<input checked="" type="checkbox"/>	Single-Select	2	0	1	 
  	Child/Parent	<input checked="" type="checkbox"/>	Single-Select	0	2	2	 
  	Psychosocial	<input checked="" type="checkbox"/>	Single-Select	0	5	3	 

Creating a New Template

Maybe you'd rather "start from scratch in designing your care plan template.

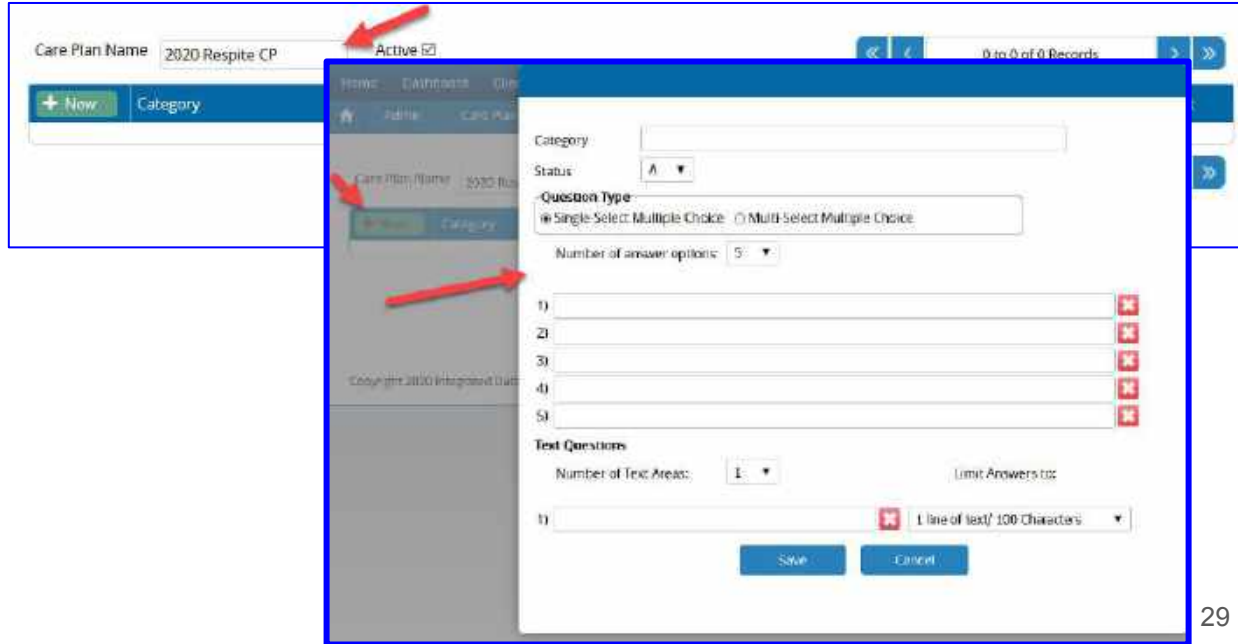
Click **New**,

Then give your new template a **Care Plan Name** - and then click **SAVE**.

Now you're ready to start setting up the care plan with the questions and text boxes that will serve your purposes.

Recommendation: Sketch out how you'd like it to look, and work from that.

When you want to see what it will look like, test it on that "dummy client" that I recommended at the beginning of this webinar. Easy to add some information - and then delete it if you need to make some 'tweaks' - without having to worry about working with real data on a real client.



















Things to Consider

Depending upon your client population, you may wish to establish different types of Care Plan templates.

A good example of this is if you work with both pediatric clients, as well as geriatric clients. The assessment data you gather for each may look a bit different.

You can have as many care plan templates as you wish.

At a client's Plan of Care tab, you'll be able to see which templates have been used, and for what range of dates.

+ New	Plan Type	Authorized Start Date	Authorized End Date
   	Geriatric Intake	07/31/2020	09/29/2020
   	Geriatric Intake	06/01/2020	07/29/2020
   	Geriatric Intake	07/01/2020	05/31/2020
   	Geriatric Intake	12/01/2018	03/28/2020

Status: Active

1 to 5 of 5 Records




+ New	Description	Active	Created	Created By	Updated	Updated By
   	2020 New Intake	<input checked="" type="checkbox"/>	8/27/2020 1:20:25 PM	Lynne		
   	2020 Respite & Comp Care	<input checked="" type="checkbox"/>	8/27/2020 2:03:52 PM	Lynne		
   	Geriatric Intake	<input checked="" type="checkbox"/>	8/27/2020 2:03:32 PM	Lynne		
   	Original	<input checked="" type="checkbox"/>	8/19/2020 10:38:18 AM	Lynne	8/19/2020 10:38:29 AM	Lynne
   	Pediatric Intake	<input checked="" type="checkbox"/>	8/27/2020 2:03:19 PM	Lynne		

Client: Powell, Connor

Personal Data | Attachments | Charting | Contacts | Custom Fields | Directions/Misc | Exclusions/P

Needs | Notes | Plan Of Care (485) | Reminders | Service Orders | Supervise

Columns Chooser

+ New    Plan Type | Assessed D

Choose Care Plan Template

- Select
- Select
- 2020 New Intake
- 2020 Respite & Comp Care
- Geriatric Intake
- Original
- Pediatric Intake

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Completing the Care Plan

The Care Plan can be completed by any office user with security access to update client information.

If you complete the care plan via the Mobile Site or Mobile App, you have the capability of having it electronically signed.

Otherwise, you'll be able to print the completed care plan with space provided for signatures.



Completing the Care Plan

Fox, Pearl

- Personal Data
- Contact (8)
- Family (6)
- Visit History (3)
- Charting
- Notes (7)
- Plan of Care (0)

Fox, Pearl

New

GENERATIONS
Residence System

Home Logour

Back

Add Plan Of Care

Fox, Pearl

- Activities Permitted (0)
- Allergies (0)
- Assessment Info
- Care Plan
- Certification Period
- Client Information
- DME and Supplies (0)
- Functional Limitations (0)

Client Name : Fox, Pearl
Address 1 : 2625 Denison Street
Address 2 :
City : Mt. Pleasant
State : MI
ZIP : 48856
Phone 1 : 989-546-4513
Phone 2 :

Add Plan Of Care

Fox, Pearl

- Activities Permitted (0)
- Allergies (0)
- Assessment Info
- Care Plan
- Additional Client Information
- Medical Information
- Pets In The Home (0)
- Height and Weight
- Medication Allergies
- Dental Problems (0)
- Vision Loss (0)
- Hearing (0)
- Mental Health (0)
- Smoking
- Drinking
- Allergies: Food & Other
- Toileting (0)
- Preparing Food (0)
- Housekeeping
- Shopping (0)

Care Plan

Fox, Pearl

- Additional Client Information
- Medical Information
- Pets In The Home (0)
- Height and Weight
- Medication Allergies
- Dental Problems (0)
- Vision Loss (0)

ID Number

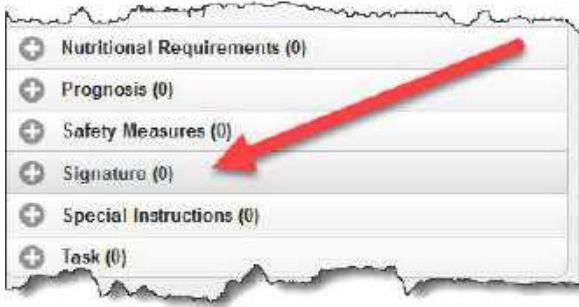
Insurance Name

Save

Choose Care Plan Template



- 2020 New Intake
- 2020 Respite & Comp Care
- Geriatric Intake
- Original
- Pediatric Intake

Completing the Care Plan



Special Instructions

Mr. DoRight is a fairly active man who has experienced some mild dizziness due while his doctor is regulating his blood pressure. He has... His family would like him to have daily companionship, along with light housekeeping (laundry, dishes, trash removal). Mr. DoRight's daughter takes care of groceries, providing meals. He enjoys watching sports on TV, especially boxing, enjoys working in his raised vegetable garden and does the daily NY Times crossword puzzle. Mr. DoRight has one dog, "Honey" - an elderly, friendly, quiet, medium-sized lab mix. The back of the house, and the back yard is fenced. Mr. DoRight's daughter takes care of feeding/watering the dog.

Name: Dudley <u>DoRight</u>	Name: Lynne Ingraham
Title: Client	Title: Care Manager
Date: 8/24/2020	Date: 8/24/2020
Signature : 	Signature : 

Once all data has been entered, multiple signatures can be saved to this document.



When you "Tap to Sign", you'll be prompted to enter the individual's title, name, and then that person can use their finger or a stylus to sign.

Completing the Care Plan on Paper

[CMS 485 Report](#)
[Care Plan Report](#)
[Print Assessment Form](#)
[Close POC](#)

Client: DoRight, Dudley

[485 Start*](#)
[Care Plan](#)
[CMS-487*](#)
[Diagnosis*](#)
[DME/Safety/Nutritional/Allergies*](#)
[Goals*](#)

[Limitations/Activities/Mental Status*](#)
[Prognosis*](#)
[Medications*](#)
[Orders*](#)
[Physician*](#)
[Special Instructions](#)
[Task](#)

If you will not have an internet connection at the client's home when completing the assessment, you have the additional option to print a blank form - this will show all of the fields for all POC tabs. This could be printed out & taken with you to provide a form to complete for the assessment.

The only fields that will be pre-filled on the form will be the client contact information, diagnosis and physician (from Personal Data). You would complete the remainder manually.

Client Information

Name: Dudley, Dudley DOB: 02/23/1952 Start Of Care: NPI:

Phone: 870-213-2556 Phone2: Location: SAE

Diagnosis: Other substance abuse with stimulant-induced psychotic disorder with hallucinations EW ID: 213296

Address: 10 Sahway Lane, Ft. Adams, MO 40074

Assessed By: Date:

Revised By: Date:

Physician(s)

Name: Carolyn Carr, MD Specialty: Phone: 646-696-6106

Address: 20 W. Adams, Suite 102, Canton, MS 39056 Alt Phone: 323-957-4388

Functional Limitations

<input type="checkbox"/> Amputation	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Legally Blind	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Endurance	<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Contracture	<input type="checkbox"/> Ambulation
<input type="checkbox"/> Other	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech	

Other Descr:

Activities Permitted

<input type="checkbox"/> Complete Bed Rest	<input type="checkbox"/> Partial Weight Bearing	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Bed rest BRN
<input type="checkbox"/> Independent At Home	<input type="checkbox"/> Walker	<input type="checkbox"/> Up As Tolerated	<input type="checkbox"/> Crutches
<input type="checkbox"/> No Restrictions	<input type="checkbox"/> Transfer Bed/Chair	<input type="checkbox"/> Cone	<input type="checkbox"/> Specimen Prescribed
<input type="checkbox"/> Other (Specify):			

Other Descr:

Plan of Care Attachments

Client: Burlock, John

Personal Data	Attachments	Charting	Contacts	Custom Fields	Directions/Misc	Exclusions/Preferences	History	Interruptions of Service
Needs	Notes	Plan Of Care (485)	Reminders	Service Orders	Supervisory Visits	Visit History	Wellness	

Column Chooser

0 to 0 of 0 Records

+ New	Attachment	Plan Type	Assessed Date	Assessment Revised	Authorized Start Date	Authorized End Date	Name	Start Care Date
-------	------------	-----------	---------------	--------------------	-----------------------	---------------------	------	-----------------

If you wish to use your own, custom care plan document, and you do not wish to recreate it in Generations, you can complete your form manually, and then attach each client's in their POC tab.

Click "Attachment", then complete the fields supplied. Browse to and choose the saved document, then click Save.

We do recommend PDF, but some other formats are supported.

Start Care Date:

Certification From: 08/27/2020

Certification Through: 10/25/2020

Attachment Name:

Choose File: No File Chosen

PDF(Recommended), Word Documents, RTF, JPG, PNG and GIF Supported.
(Maximum file size: 20 MB)

Viewing the Plan of Care Tab

Information Summary Audit Outlook Email Calendar Close

Client: Metcalf, Anthony

Personal Data	Attachments	Charting	Contacts	Custom Fields	Directions/Misc	Exclusions/Preferences	History	Interruptions of Service
Needs	Notes	Plan Of Care (485)	Reminders	Service Orders	Supervisory Visits	Visit History	Wellness	

Column Chooser

1 to 5 of 5 Records

	Plan Type	Authorized Start Date	Authorized End Date	Name
 	2020 New Intake	08/01/2020	10/31/2020	
 	2020 New Intake	04/01/2020	07/31/2020	
 	Original	01/01/2019	03/31/2019	
 	Original	09/01/2018	12/31/2018	
 	Attachment	06/22/2018	08/31/2018	Assessment/CarePlan.docx

You can easily see which template is being used by looking at the client's Plan of Care tab.

I'm displaying four fields here - including

- the Plan Type (which is either the name of the template OR that it's an attachment)
- Start Date & End Date of the Care Plan - so the range of dates for which it's in effect, and the
- Name field. (you can see here the name of the item that is attached)

Sharing the Care Plan



The CMS485 can be printed from either the client's POC tab, or from the client reports area.

The Care Plan report can also be printed from those areas.

When you generate the Care Plan Report, designate the font size you wish to use, and also whether you wish it to be titled a "Care Plan" or an "Assessment".

If areas of the Care Plan tab have no entries they can be excluded.

The screenshot shows a dialog box titled "Care Plan Report". It contains the following elements:

- A "Font Size" label followed by a dropdown menu with "Select" and a downward arrow.
- A "Report Title" label followed by two radio buttons: "Care Plan" (which is selected) and "Assessment".
- A checkbox labeled "Hide categories and questions not selected (Care Plan tab)".
- Two buttons at the bottom: "OK" and "Cancel".

The Care Plan is full of identifiable, personal information about your client. Instead of emailing a care plan report to the caregiver - web-enable the caregiver so they can review their client's care plan securely online. (Clients and their contacts can be given capability to view their care plan online, as well.)

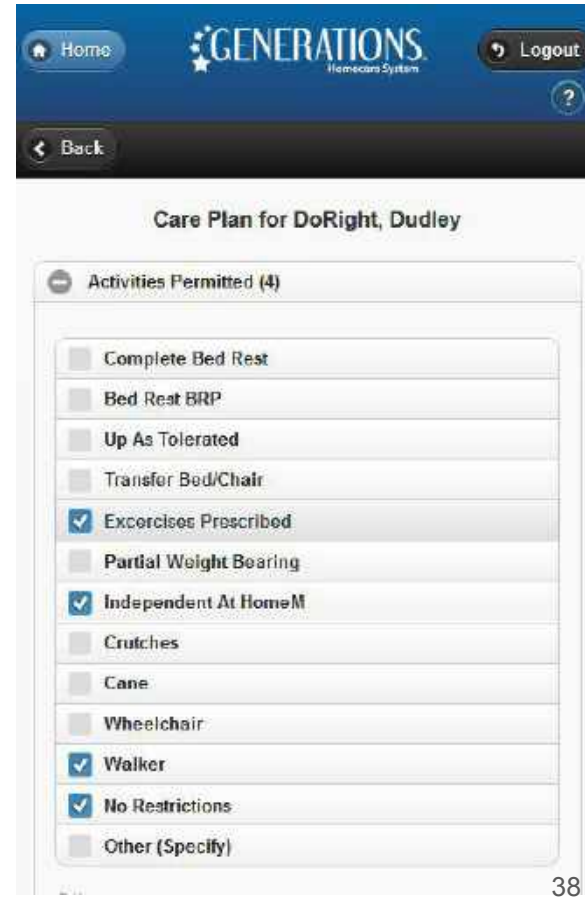
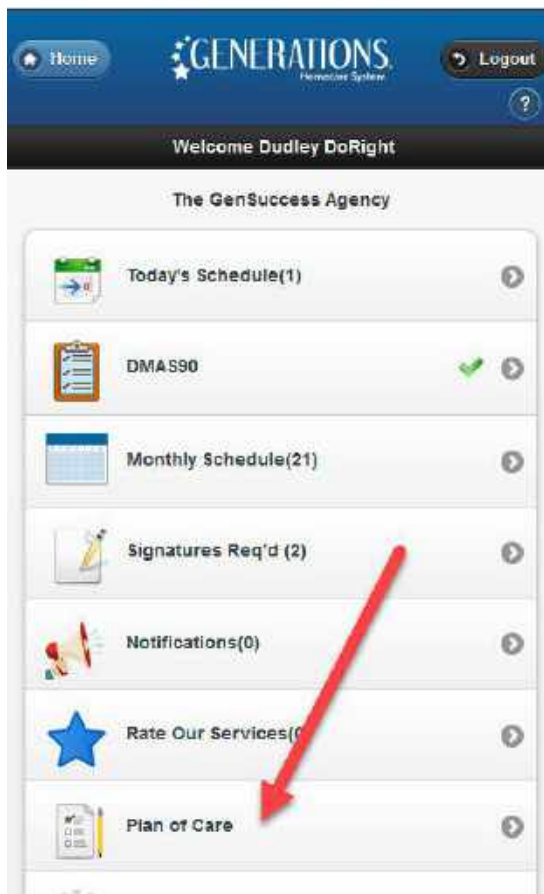
Sharing the Care Plan Online with Clients, Contacts & Caregivers

Viewing Plan of Care

If you want your clients, their contacts, and their caregivers to be able to review the client's care plan online, you need to enable that in the Company Settings/Web Portal, and then web-enable the individual people.


View of the Care Plan for clients, contacts, and caregivers is **read-only**.

If the Care Plan is an attachment, it will open up in the PDF reader on the client/contact/caregiver device.



Associated Reports

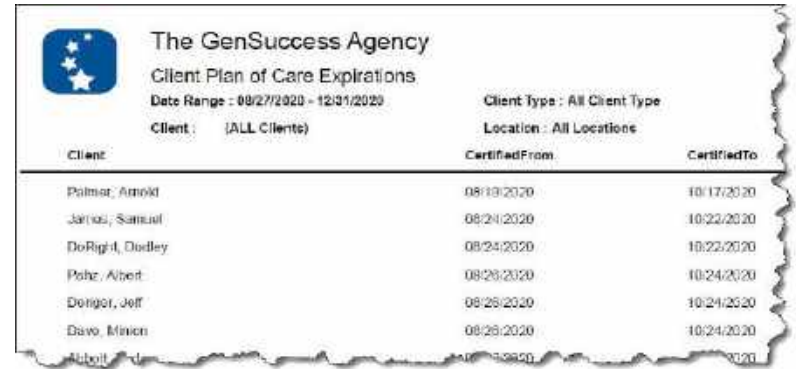
★	Plan of Care - CMS-485	Prints the last plan of care for the selected client.
★	Plan of Care - Private Duty	Care plan report by client.
★	Plan of Care - Tasks (7 day)	1 to 4 weeks summary report for plan of care of various clients.
★	Plan of Care Ending	Plans of care ending by date range.



The GenSuccess Agency 7-day plan of care report

Client Name:	DoRight, Dudley
Client Address:	56 Railway Lane St. Johns, MI, 48879
Plan of Care:	08/23/2020 - 08/29/2020
Signature:	

TASKS	Su 08/23/2020	Mo 08/24/2020	Tu 08/25/2020	We 08/26/2020	Th 08/27/2020	Fr 08/28/2020	Sa 08/29/2020	Initial
Food & Fluids								
Encourage fluids		1 []	1 []	1 []	1 []	1 []		
Prepare & serve snacks		1 []	1 []	1 []	1 []	1 []		
Home Care								
Bathroom - Clean Mirror		1 []	1 []	1 []	1 []	1 []		
Bathroom - Clean Surfaces		1 []	1 []	1 []	1 []	1 []		



The GenSuccess Agency
Client Plan of Care Expirations
Date Range : 08/27/2020 - 12/31/2020
Client : (ALL Clients)
Client Type : All Client Type
Location : All Locations

Client	CertifiedFrom	CertifiedTo
Palmer, Arnold	08/18/2020	10/17/2020
Jarvis, Samuel	08/24/2020	10/22/2020
DoRight, Dudley	08/24/2020	10/22/2020
Patz, Albert	08/26/2020	10/24/2020
Dongor, Jeff	08/28/2020	10/24/2020
Davo, Minion	08/28/2020	10/24/2020
Albott, ...	08/28/2020	10/24/2020

Expiring Care Plan can also be seen at the Dashboard



Operational

Scheduled Work	2,119	Complete Terminated Bus	2	Driver Expenditure Paid Out	1
Scheduled Hours	2,700.75	Appropriation Minimized Mile	9	5-Minute Service Linking	27
Cancelled Miles	17	Client Holidays	4	Plan of Care Ending	11

Other Associated Reports

Client Information Summary	Client summary report that can be given to employees standing in a line.
★ Client Interruption of Service	Report will show all Interruptions of service occurring along with any existing schedules during that time.
★ Client Medication	Client Medication.



The GenSuccess Agency
Client Medication

Client: All Clients Client Type: All Client Type
Location: All Locations Status: A

Client Name: Abbott, Bud Care Plan Name:

Drug	Dose	Frequency	Route	Order Type	Start Date	DC Date	Reason
Drug A	5mg	daily	oral	Discontinued	08/01/2017	07/13/2020	BP
Drug A	7 mg	daily	oral	Changed	07/13/2020		BP

Nurse Signature: _____ Date: _____


Physician Signature: _____ Date: _____

Other Associated Reports



Medication Administration Record (MARS)

Creates a monthly report based on information in the Medications tab of the Plan of Care for use by caregivers to record when medications are administered



The GenSuccess Agency
Medication Administration Record
 Plan of Care Period 08/01/2020 - 08/31/2020

Name: DoRight, Dudley **Month/Year:** August / 2020

Allergies: Penicillin.
 No known food allergies.

Medication	Times	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Drug Name: Med A Start Date: 02/01/2020 DC Date: Frequency: daily Route : oral Dosage : 20 mg																																	
Reason : BP	Notes : small white tab																																
Drug Name: Med A Start Date: 12/23/2018 DC Date: 02/01/2020 Frequency: daily Route : oral Dosage : 10 mg																																	
Reason : BP	Notes : small white tab																																

Best Practices

- Use the mobile app or site when doing an intake, and complete the Care Plan online, and get those electronic signatures
- Web-enable your caregivers, clients and their contacts so they can see the care plan online
- Keep track of which clients have a care plan that is expiring - so you can do the new one. (Suggestion: on the first day of each month, run a Care Plan Ending report to see which ones are expiring in the next 60 days...)
- Customize the Care Plan in Generations to meet your needs.
- Create multiple care plan templates to accommodate the various types of clients you serve.
- When customizing your care plan templates, 'practice' using a 'dummy client'.
- If a client has more than one care plan with the same date ranges, the caregiver/client will ONLY see the one most recently entered/attached that is in effect at that time.
- Obviously - the Care Plan report contains a lot of identifiable client information. Web-enable your caregivers, clients and their contacts so they can review the report securely via the app or web portal.

Read More About It



Check out the user documentation on the following **topics** to learn more. Use the search bar at the top of the Help area & look for these...

- Plan of Care
- POC
- Care Plan
- CMS 485
- App for Office Staff
- Web Portal
- Tasks

Need assistance?

Contact support using Live Chat (M-F 9-5 EST)

- Available from the Help area in Generations, or from
- www.idb-sys.com OR www.homecaresoftware.com
- Email: support@idb-sys.com
- Phone: 989-546-4512

For emergency after-hours support - reach our on-call staff at 989-546-4512 x1





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