

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157587	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
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NAME OF PROVIDER OR SUPPLIER AMERICAN HOME HEALTH AND HOSPICE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 79 S CR 700 W CUMBERLAND, IN 46229
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N0000	<p>This visit was for a home health state relicensure survey.</p> <p>Survey Dates: February 19-21, 2013</p> <p>Facility Number: 011171</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 70-90 Home Health Aide Only: 10-20 Personal Care Only: 0 Total: 80-110</p> <p>Sample: RR w/HV: 3 RR w/o HV: 2 Total: 5</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 27, 2013</p>	N0000		

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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N0408	<p>410 IAC 17-10-1(d) Licensure Rule 10 Sec. 1(d) Disclosure of ownership and management information must be made to the department at the time of the home health agency's initial request for licensure, for each survey, and at the time of any change in ownership or management. The disclosure must include the names and addresses of the following:</p> <p>(1) All persons having at least five percent (5%) ownership or controlling interest in the home health agency. (2) Each person who is: (A) an officer; (B) a director; (C) a managing agent; or (D) a managing employee; of the home health agency and evidence supporting the qualifications required by this article. (3) The corporation, association, or other company that is responsible for the management of the home health agency. (4) The chief executive officer and the chairman or equivalent position of the governing body of that corporation, association, or other legal entity responsible for the management of the home health agency.</p> <p>Based on Indiana State Department of Health (ISDH) document review and interview, the agency failed to notify ISDH in writing of all changes in management for 1 of 1 agency reviewed with the potential to affect all the patients of the agency.</p>	N0408	<p>N 408 Administrator met with Nursing Supervisor on 02-21-13 to discuss non-compliance to this rule along with examples cited at the exit interview of the survey. Reviewed the status of the formulated letter of staffing change, that took place on 2/1/13, was faxed on 02/20/13 to notify ISDH in writing and was accepted for Alternate Administrator on 02/20/13.</p>	02/27/2013	

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	<p>The findings include:</p> <ol style="list-style-type: none"> 1. The written information on file with ISDH evidenced Employee M was listed as Alternate Administrator and Alternate Nursing Supervisor. Employee N was listed as Nursing Supervisor. 2. During an interview on 2/19/13 at 11:21 AM, Employee P indicated self to be Administrator for the agency, Employee N to be Alternate Administrator/Nursing Supervisor, and employee O to be the Alternate Nursing Supervisor. Employee P indicated Employee M had been the Alternate Administrator and Alternate Nursing Supervisor but was no longer with the agency as of 3 to 4 weeks ago. Employee P indicated he had not notified ISDH of the change but was in the process of formulating the letter of staffing change that took place on 2/1/13. 		<p>Change in Alternate Nursing Supervisor(ADON) was accepted by ISDH on 02/27/13. Administrator or designee will notify ISDH in writing about change In management staff as soon as change occurs and new staff with required qualification and experience is hired. Any change in staff will be disclosed at each survey and at the time of any change in ownership or management. Administrator or designee will be responsible for monitoring these corrective action to ensure that this deficiency is corrected and will not recur. Plan of correction was forwarded to Governing Board for review before submission. .</p>		

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N0522	<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:</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure Skilled Nursing (SN), Physical Therapy (PT), Occupational Therapy (OT), and Home Health Aide (HHA) visits as ordered on the plan of care and measure wounds as required by agency policy in 3 of 5 records reviewed with the potential to affect all the agency's patients that receive SN, PT, OT, and HHA services. (#1, #3, #5).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency policy titled "Wound Assessment and Documentation" undated states, "For consistent evaluation, it is advisable for the case manager to measure / stage the wound the first visit each week or PRN [as needed]." 2. The agency policy titled "Patient Notification of Changes in Care" policy number HH:2-017.1 undated 	N0522	<p>N 522 Clinical Supervisor met with clinical staff on 3/8/13 to in-service/discuss the non-compliance of this Rule along with the examples cited at the exit interview of the survey. Distributed the policies that support compliance to this Rule. Developed a calendar worksheet to track visits made by SN and weekly wound measurements and to reflect current physician orders for frequency and duration of medical care of the agency clients. Beginning week of March 4, 2012 and completed by March 15, 2013, 100% of active clients receiving wound care by a SN will be audited for evidence that SN measured wound at initial visit and then weekly as per agency policy. 25% of the clinical record will be audited quarterly to ensure that medical plan care is followed by the clinical staff as ordered by the physician and orders were received and physician was notified of any change in plan of care, including extra visits as well as missed visits. Also developed a missed visit report form to be used to reflect the reason for the missed visits/ or therapy evaluation and notification to the physician and the agency office.</p>	03/15/2013	

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	<p>states,"When a visit cannot be made because of unforeseen problems, personnel will immediately notify the office."</p> <p>3. Clinical record #1, start of care 12/31/12, contained a plan of care dated 12/31/12 - 02/28/13 that identified the patient had a wound. Review of the Nursing Visit Record and Comprehensive Adult Assessment evidenced the following:</p> <p>A. The SN visited patient on 12/31/12 and 1/20/13 and measured wound. The record failed to evidence the SN measured wound weekly.</p> <p>B. On 2/21/13 at 9:44 AM, employee N, Alternate Administrator, indicated that wounds needed to be measured weekly per agency's policy.</p> <p>4. Clinical record #3, start of care 12/7/12, contained plan of cares for the certification periods dated 12/7/12 - 2/4/13 and 2/5/13 - 4/5/13. The plan of care for the certification period dated 12/7/12 - 2/4/13 included orders for PT orders 1 time a week for 1 week then 2 times a week for 8 weeks and for HHA orders 2 times a week for 8 weeks. The plan of care for the certification period</p>		<p>Director of Nursing or designee will be responsible for monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur. Plan of correction was forwarded to Governing Board for review before submission. .</p>				

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	<p>2/5/13 -4/5/13 included orders for PT 2 times a week for 9 weeks and HHA 2 times a week for 9 weeks. Review of the Therapy Visit Notes and Home Health Aide Patient Care Record evidenced the following:</p> <p>A. The record evidenced an extra PT visit for the week of 2/10/13 to 2/16/13.</p> <p>On 2/21/13 at 5:50 PM, employee N, Alternate Administrator, indicated that PT made an extra visit the week of 2/10/13 to 2/16/13.</p> <p>B. The record evidenced a HHA missed visit for the week of 1/20/13 - 1/26/13.</p> <p>On 2/21/13 at 5:51 PM, employee N, Alternate Administrator, indicated there was a missed HHA visit for the week of 1/20/13 to 1/26/13.</p> <p>C. The record evidenced a missed HHA visit for the week of 1/27/13 - 2/2/13.</p> <p>On 2/21/13 at 5:52 PM, employee N, Alternate Administrator, indicated there was a missed HHA visit the week of 1/27/13 to 2/2/13.</p> <p>5. Clinical record #5, start of care 1/1/13, contained plan of care dated</p>			

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	<p>1/1/13 - 3/1/13. The plan of care included orders for OT to evaluate and treat patient, HHA 2 times a week for 9 weeks, and SN 4 times a week for 1 week then 7 times a week for 2 weeks then 3 times a week for 7 weeks to assess, perform, and instruct wound care. Review of the Home Health Aide Patient Care Record, Comprehensive Adult Assessment, and Nursing Visit Record evidenced the following:</p> <p>A. OT did not preformed an initial evaluation. The record failed to evidence any documentation of OT evaluation.</p> <p>On 2/21/13 at 6:07 PM, employee N, Alternate Administrator, indicated that OT did not evaluate patient and failed to document in chart reason for no evaluation.</p> <p>B. The record failed to evidence any HHA visits week 1.</p> <p>On 2/21/13 at 6:08 PM, employee N, Alternate Administrator, indicated there were no HHA visits for week of 1/1/13 to 1/5/13.</p> <p>C. The record failed to evidence 2 HHA visits were made the week of 1/13/13 to 1/19/13.</p>				

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	<p>On 2/21/13 at 6:09 PM, employee N, Alternate Administrator, indicated there was a missed HHA visits for week of 1/13/13 to 1/19/13.</p> <p>D. The record failed to evidence 2 HHA visits were made the week of 1/20/13 to 1/26/13.</p> <p>On 2/21/13 at 6:10 PM, employee N, Alternate Administrator, indicated there was a missed HHA visit the week of 1/20/13 to 1/26/13.</p> <p>E. The record failed to evidence 2 HHA for the week of 1/27/13 to 2/2/13.</p> <p>On 2/21/13 at 6:11 PM, employee N, Alternate Administrator, indicated there was a missed HHA visit the week of 1/27/13 to 2/2/13.</p> <p>F. The record failed to evidence 3 SN visits for the week of 1/14/13 and 1/15/13.</p> <p>On 2/21/13 at 6:12 PM, employee N, Alternate Administrator, indicated a SN visit was missed the week of 1/14/13 and 1/15/13.</p> <p>G. the record evidenced the SN</p>			

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	<p>measured wound on 1/1/13. The record failed to evidence the wound being measured on any more SN visits during this certification period.</p> <p>On 2/21/13 at 6:13 PM, employee N, Alternate Administrator, indicated that wounds needed to be measured weekly per agency's policy.</p>			

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N0524	<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 policy review, record review, and interview, the agency failed to ensure the plan of care included all Durable Medical Equipment (DME) in 1 of 5 records reviewed (#1) and was signed by the physician timely for 2 of 5 records reviewed (#2 and 3) with the potential to affect all the agency's patients.</p> <p>The findings include:</p>	N0524	<p>N 524 Clinical Supervisor met with clinical staff on 3/8/13 to in-service/discuss the non-compliance of this Rule along with the example cited at the exit interview of the survey. Distributed the policies that support compliance to this Rule. Beginning week of 3/4/13, 100% of the new start of care paperwork will be audited for its timely submission to the office as per agency policy to ensure that</p>	03/15/2013			

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	<p>1. Facility policy titled "Care Planning Process" policy number HH:2-004.2 undated states, "The clinical plan of care includes: ... L. Supplies and equipment required."</p> <p>2. Clinical record #1, start of care 12/31/12, included a Home Health Certification and Plan of Care (POC) for the certification period dated 12/31/12 to 2/28/13. DME listed on the plan of care included a cane, walker, elevated toilet seat, right leg prosthesis, tub shower bench, and wheelchair hand bars in bathroom.</p> <p style="padding-left: 40px;">A. During a home visit on 2/19/13 at 3:05 PM, a cane was not present. When asked, the patient denied owning a cane.</p> <p style="padding-left: 40px;">B. On 2/21/13 at 5:15 PM, employee N, Alternate Administrator, indicated the cane did not belong on the plan of care.</p> <p>3. Clinical record #2, start of care 12/12/12, included a Home Health Certification and Plan of Care with a certification period dated 12/12/12 to 2/9/13. The record evidenced a MD signature on 1/16/13.</p>		<p>medical plan of care is prepared and sent to be signed by the attending physician within 30 days of the start of care. Plan of care must include the types of the services and durable medical equipment required for the client is listed. 25% of the clinical record will be audited quarterly to ensure that:</p> <p>A) Medical plan of care includes types of services, supplies and durable medical equipment required for patient care.</p> <p>B) Medical plan of care is certified by the attending physician by signing the plan of care within 30 days of the start of care.</p> <p>Director of Nursing or designee will be responsible for monitoring of these corrective actions and to ensure that this deficiency is corrected and will not recur.</p> <p>Plan of correction was forwarded to Governing Board for review before submission</p>				

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	<p>On 2/21/13 at 9:45 AM, employee N, Alternate Administrator, indicated the plan of care did not meet the agency's 30 day policy deadline.</p> <p>4. Clinical record #3, start of care 12/7/12, included a Home Health Certification and Plan of Care with a certification period dated 12/7/12 to 2/4/13. The record evidenced a MD signature on 1/17/13.</p> <p>On 2/21/13 at 5:58 PM, employee N, Alternate Administrator, indicated the plan of care did not meet the agency's 30 day policy deadline.</p> <p>5. The agency policy titled "Physician Participation in Plan of Care" policy number HH:2-005.1 undated states, "The attending physician will certify the need for the home health care services by signing the plan of care/treatment within 30 days of the start of care."</p>			
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N0537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed ensure the skilled nurse (SN) measured wounds as required by agency policy in 2 of 5 records reviewed with the potential to affect all the agency's patients who have wounds. (#1 and #5).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency policy titled "Wound Assessment and Documentation" undated states, "For consistent evaluation, it is advisable for the case manager to measure / stage the wound the first visit each week or PRN [as needed]." 2. Clinical record #1, start of care 12/31/12, contained a plan of care dated 12/31/12 - 02/28/13 that identified the patient had a wound. Review of the Nursing Visit Record and Comprehensive Adult Assessment evidenced the following: 	N0537	<p>N 537 Clinical Supervisor met with clinical staff on 3/8/13 to in-service/discuss the non-compliance of this Rule along with the examples cited at the exit interview of the survey. Distributed the policies that support compliance to this Rule. Developed a calendar worksheet to track visits made by a SN and wound measurements completed at initial visit and then weekly and to reflect current physician orders for frequency and duration of medical care of the agency clients. Beginning week of March 4, 2012 and completed by March 15, 2013, 100% of active records receiving wound care by a SN will be audited for evidence that SN measured wound at initial visit and then weekly as per agency policy. 25% of the clinical record(active and discharged) will be audited quarterly to ensure that SN measured wounds weekly as required by the agency policy. Director of Nursing or designee will be responsible for monitoringof these corrective actions to ensure that this deficiency is correctedand will not recur. Plan of correction was forwarded to Governing Board for</p>	03/15/2013			

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	<p>A. The SN visited patient on 12/31/12 and 1/20/13 and measured the wound. The record failed to evidence the SN measured wound weekly.</p> <p>B. On 2/21/13 at 9:44 AM, employee N, Alternate Administrator, indicated that wounds needed to be measured weekly per agency's policy.</p> <p>3. Clinical record #5, start of care 1/1/13, contained plan of care dated 1/1/13 - 3/1/13. The plan of care included orders SN 4 times a week for 1 week then 7 times a week for 2 weeks then 3 times a week for 7 weeks to assess, perform, and instruct wound care. Review of the Nursing Visit Record evidenced the SN measured wound on 1/1/13. The record failed to evidence the wound being measured on any more SN visits during this certification period.</p> <p>On 2/21/13 at 6:13 PM, employee N, Alternate Administrator, indicated that wounds needed to be measured weekly per agency's policy.</p>		review before submission.		

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NAME OF PROVIDER OR SUPPLIER AMERICAN HOME HEALTH AND HOSPICE CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 79 S CR 700 W CUMBERLAND, IN 46229
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N0597	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry.</p> <p>Based on personnel file review and interview, the agency failed to ensure home health aides (HHA) were entered on and in good standing on the state aide registry for 1 of 10 HHA files reviewed of HHAs employed by the agency with the potential to affect all patients receiving HHA services. (E)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Personnel file E, date of hire 11/2/12, failed to evidence the agency had checked to see if the aide was on and in good standing on the state aide registry. The file evidenced a Home Health Aide Registry Application was not submitted until 2/20/13. On 2/21/13 at 4:46 PM, employee N, Alternate Administrator, indicated employee E was a Certified Nurse Aide and not officially registered as a HHA. 	N0597	<p>N 597 Clinical Supervisor met with office(HR) and home health aides on 3/8/13 to in-service/discuss the non-compliance of this Rule along with the example cited at the exit interview of the survey. Beginning week of March 4, 2013 and completed by March 15, 2013, 100% of personal records of "home health aides" will be audited for the evidence that home health aides are in good standing on State Aide Registry. Also clinical supervisor or designee will ensure that all new hires as home health aide are in good standing on State Aide Registry prior to their first patient contact, then annually Director of Nursing or designee will be responsible for monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur. Plan of care was forwarded to GB for review before submission.</p>	03/15/2013

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N0606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on policy review, record review, and interview, the agency failed to ensure the registered nurse who supervised the Home Health Aide (HHA) assured the HHA followed the aide / homemaker plan of care so that goals could be met in 3 of 5 records reviewed with the potential to affect all patients of the agency who receive Home Health Aide services (#3, #4, and #5).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Job Descriptions" undated states, "Responsibilities of the home health aide include, but are not limited to, the following: ... 11. Adhering to the Organization's documentation and care procedures and standards of personal and professional conduct." 2. Clinical record #3, start of care 12/07/12, contained a document titled "Aide / Homemaker Care Plan" that identified the HHA to was assist with 	N0606	<p>N 606 Clinical Supervisor met with clinical staff, including registered nurses, therapists and home health aides on 3/8/13 to in-service/discuss the non-compliance of this Rule along with the examples cited at the exit interview of the survey. Distributed the policies that support compliance to this Rule. SN and therapist were reinforced to supervise home health aides(HHA) to ensure aide/homemaker plan of care is followed and that HHAs follow organization's documentation and care procedures and standards of personal and professional conduct. Beginning week of 3/4/13, 100% of the HHA visit records of active clients will be audited for the evidence that aide/homemaker plan of care was followed and documented as per State Rues and agency policies. 25% of the clinical record will be audited quarterly to ensure that a supervising registered nurse, or therapist in therapy only cases, make supervisory visits to the client's residence to ensure that care was provided and</p>	03/15/2013

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	<p>cleaning/filing nails and soaking feet each visit. Review of the Aide/Homemaker Care Plan evidenced the following:</p> <p>A. The HHA visited patient on 1/9/13, 1/11/13, 1/15/13, 1/18/13, 1/22/13, 2/5/13, 2/8/13, 2/12/13, and 2/15/13. The record failed to evidence soaking feet was preformed by the HHA on these visits.</p> <p>On 2/21/13 at 5:56 PM, employee N, Alternate Administrator, indicated the HHA needed to document soaking feet.</p> <p>B. The HHA visited patient on 1/9/13. The record failed to evidence cleaning/filing nails was preformed by HHA on this visit.</p> <p>On 2/21/13 at 5:57 PM, employee N, Alternate Administrator, indicated the HHA needed to document cleaning/filing nails.</p> <p>3. Clinical record #4, start of care 1/14/13, contained a document titled "Aide / Homemaker Care Plan" that identified the HHA was to provide total support with shampooing and soaking feet each visit. Review of the</p>		documented by the aide as per plan of care. Director of Nursing or designee will be responsible for monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur. Plan of correction was forwarded to GB for review before submission.	

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	<p>Aide/Homemaker Care Plan evidenced the following:</p> <p>A. The HHA visited patient on 1/16, 1/18,1/23, 1/29, 1/31, 2/5, 2/7, and 2/11. The record failed to evidence shampooing was preformed by the HHA on these visits.</p> <p>B. The HHA visited patient on 1/16, 1/18, 1/23, 1/25, 1/29, 1/31, 2/5, 2/7, and 2/11. The record failed to evidence soaking feet was preformed by the HHA on these visits.</p> <p>C. On 2/21/13 at 5:58 PM, employee N, Alternate Administrator, indicated the HHA needed to document shampooing and soaking feet.</p> <p>4. Clinical record #5, start of care 1/1/13, contained a document titled "Aide / Homemaker Care Plan" with orders for HHA to assist with cleaning / filing nails, soaking feet, and mouth care each visit. Review of the Aide / Homemaker Care Plan evidenced the following:</p> <p>A. The HHA visited patient on 1/10/13, 1/11/13, 1/15/13, 1/22/13, and 1/30/13. The record failed to evidence cleaning / filing nails was preformed by HHA on</p>			

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	<p>these visits.</p> <p>B. The HHA visited patient on 1/10/13, 1/11/13, 1/15/13, 1/22/13, 1/30/13 , 2/6/13, and 2/8/13. The record failed to evidence soaking feet was preformed by HHA on these visits.</p> <p>C. The HHA visited patient on 1/10/13, 1/11/13, 1/22/13, 1/30/13, 2/6/13, and 2/8/13. The record failed to evidence mouth care was preformed by HHA on these visits.</p> <p>D. On 2/21/13 at 5:59 PM, employee N, Alternate Administrator, indicated the HHA needed to document cleaning / filing nails, soaking feet, and mouth care.</p>			