

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157596	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/18/2012
NAME OF PROVIDER OR SUPPLIER INCARE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 JOLIET ST STE 312 DYER, IN 46311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0000	<p>This visit was for a federal home health agency recertification survey. This visit resulted in an extended survey.</p> <p>Survey date: June 12 - 18, 2012</p> <p>Facility #: 7377</p> <p>Medicaid #: 200873250</p> <p>Surveyor: Ingrid Miller, RN, PHNS</p> <p>Incare Home Healthcare, Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of two years beginning June 18, 2012, to June 18, 2014, due to being found out of compliance with the Condition of Participation 42 CFR 484.10 Patient Rights.</p> <p>Census: 246 skilled patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 25, 2012</p>	G0000			

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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G0100	Based on clinical record review, interview, observation, and policy review, it was determined the agency failed to ensure that 1 of 12 clinical records had the patient rights signed and 2 of 12 patients were treated with dignity while showering (See G 101); failed to ensure the patient and/or patient's power of attorney had received written notice of rights in advance of care for 1 of 12 records (see G 102); failed to evidence the patient and/or patient's power of attorney had been informed of all of his or her rights for 1 of 12 records reviewed (See G 103); failed to ensure the patient and/or patient's power of attorney had been informed of the right to exercise the patient rights for 1 of 12 records reviewed (See G 104); failed to ensure the patient's power of attorney had been informed of the right of the patient to have his or her property treated with respect for 1 of 12 clinical records reviewed (See G 105); failed to ensure the patient and / or patient's power of attorney had been informed of the right to voice grievances for 1 of 12 records reviewed (See G 106); failed to ensure the patient and / or patient's power of attorney had been informed the agency must investigate	G0100	G 0100-The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012	

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	complaints and must document both the existence and the resolution of the complaint for 1 of 12 records reviewed (See G 107); failed to ensure the patient and /or patient's power of attorney had been informed of the right to be informed in advance of the care to be furnished, the disciplines that would provide care, and the frequency of visits for 1 of 12 records reviewed (See G 108), failed to ensure the patient and / or power of attorney had been informed of the right to participate in the planning of care and in planning changes in the care (See G 109); failed to ensure the patient and / or patient's power of attorney had been provided advance directives and informed the patient of the agency's policies regarding advance directives for 1 of 12 records reviewed (See G 110); failed to ensure the patient / patient's power of attorney was informed of the right to confidentiality of the medical records for 1 of 12 record reviewed and the right to confidentiality was maintained for 6 of 6 patient documents observed on the floor and in window sills of the agency and 1 of 1 potential patient document found in the trash (See G 111); and failed to ensure the patient and /or patient's power of attorney had been informed of the state hotline number for complaints for 1 of 12 records reviewed (See G 116.)				

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	The cumulative effect of these systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.10: Patient rights with the potential to affect all the agency's patients.			

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G0101	<p>484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights.</p> <p>Based on clinical record review, interview, observation, and policy review, the agency failed to ensure that 1 of 12 clinical records (#10) had the patient rights signed and 2 of 12 patients were treated with dignity while showering (1 and 4) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p style="padding-left: 40px;">a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN, stated, "Verbal order ok'd [okayed] per [family member]."</p> <p style="padding-left: 40px;">b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p>	G0101	<p>G 0101-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon initial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012			

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	<p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. Regarding the patient being treated with dignity</p> <p>A. On 6/13/12 at 8:30 AM, Employee F, home health aide (HHA), was observed to give a shower to Patient #1. The shower failed to evidence the patient was treated with dignity as evidenced by the following:</p> <p>1). During the shower, Employee F failed to cover Patient #1 with a bath blanket or towel as the shower was completed. The patient was undressed and exposed with no covering for 5 minutes prior to the shower and 5 minutes after the shower was completed.</p> <p>2.) On 6/13/12 at 11:50 AM, Employee C, director of nursing (DON), indicated the patient was not covered during the observed shower and was not treated with dignity.</p> <p>B. On 6/14/12 at 9:30 AM, Employee K, HHA, was observed to give a shower to Patient #4. The HHA did not cover the patient after he/she was undressed for several minutes prior to the shower and</p>						

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	<p>after the shower. This visit failed to evidence this patient was treated with dignity as shown by the following:</p> <p>1.) During the undressing prior to the shower and dressing after the shower, the patient was undressed completely without a towel or bath blanket for dignity.</p> <p>2.) On 6/14/12 at 3:45 PM, the director of nursing indicated patient #4 was not covered for respect and privacy during the observed shower.</p> <p>3. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or</p>			

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	<p>legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>4. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>				

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G0102	<p>484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.</p> <p>Based on clinical record review, interview, document review, and policy review, the agency failed to ensure that 1 of 12 clinical records (#10) had the patient rights signed with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p style="padding-left: 40px;">a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p style="padding-left: 40px;">b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p>	G0102	<p>G 0102-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012			

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	<p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care</p>						

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	<p>Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>				

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G0103	<p>484.10(a)(2) NOTICE OF RIGHTS The HHA must maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on clinical record and policy and patient rights document review and interview, the agency failed to ensure documentation evidenced the patient's power of attorney had been informed of all of his or her rights for 1 of 12 clinical records reviewed with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p>	G0103	<p>G 0103-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012

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	<p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care</p>			

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	<p>"Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>			

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G0104	<p>484.10(b)(1)&(2) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The patient has the right to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent.</p> <p>Based on clinical record and policy and document review and interview, the agency failed to ensure the patient's power of attorney had been informed of the right to exercise his or her rights for 1 of 12 clinical records reviewed (Clinical record #10) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of</p>	G0104	<p>G 0104-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012	

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	<p>attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home heath agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment</p>				

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	<p>... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>			

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G0105	<p>484.10(b)(3) EXERCISE OF RIGHTS AND RESPECT FOR PROP The patient has the right to have his or her property treated with respect.</p> <p>Based on clinical record and policy and document review and interview, the agency failed to ensure the patient's power of attorney had been informed of the right of the patient to have his or her property treated with respect for 1 of 12 clinical records reviewed (Clinical record #10) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was</p>	G0105	<p>G 0105-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012	

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	<p>not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse</p>			

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	and to be treated with dignity." 3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."				

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G0106	<p>484.10(b)(4) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.</p> <p>Based on clinical record review, policy and document review, and interview, the agency failed to ensure the patient and / or patient's power of attorney had been informed of the right to voice grievances for 1 (#10) of 12 records reviewed with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the</p>	G0106	G 0106-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012

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	<p>patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home heath agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from</p>				

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	<p>verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>				

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G0107	<p>484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on clinical record review, policy and document review, and interview, the agency failed to ensure the patient /power of attorney had been informed the agency must investigate complaints and must document both the existence and the resolution of the complaint for 1 of 12 records reviewed (patient #10) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A,</p>	G0107	G 0107-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the</p>						

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	<p>patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>				

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G0108	<p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record review, policy and document review and interview, the agency failed to ensure the patient /patient's power of attorney had been informed of the right to be informed in advance of the care to be furnished, the disciplines that would provide care, and the frequency of visits for 1 of 12 clinical records (Clinical record #10) reviewed with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a</p>	G0108	G 0108 - The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not	07/18/2012	

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	<p>date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home heath agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ...</p>		recur in the future.				

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	<p>The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>						

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G0109	<p>484.10(c)(2) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to participate in the planning of the care.</p> <p>The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.</p> <p>Based on clinical record review, policy and document review and interview, the agency failed to ensure the patient /patient's power of attorney had been informed of the right to participate in planning the care or treatment and in planing changes in the care or treatment for 1 of 12 clinical records (Clinical record #10) reviewed with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was</p>	G0109	G 0109-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012

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	<p>not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the</p>				

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	<p>planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>				

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G0110	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record review, policy and document review, and interview, the agency failed to ensure the patient /patient's power of attorney had been informed of the agency's policies on advance directives and was provided a copy of state law for 1 of 12 clinical records (Clinical record #10) reviewed with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p>	G0110	<p>G 0110-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure</p>	07/18/2012			

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	<p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home heath agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain</p>		the deficiency is corrected and will continue to monitor so it does not recur in the future.				

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	documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity ... have health care providers comply with advanced directives in accordance with state laws."			

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G0111	<p>484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS The patient has the right to confidentiality of the clinical records maintained by the HHA.</p> <p>Based on observation, interview, review of policies, and clinical documents, the agency failed to ensure the patient / patient's power of attorney was informed of the right to confidentiality of the medical records for 1 of 12 record reviewed (#10), the right to confidentiality was maintained for 6 of 6 patient documents (#13 - 18) observed on the floor and in window sills of the agency and 1 of 1 potential patient document (#19) found in the trash with the potential to affect all the agency's patients.</p> <p>Findings include</p> <p>1. On 6/15/12 at 10 AM, many documents were observed in two back rooms of the agency. These documents were located in piles and singly placed around these back rooms with other debris including food wrappers, paper clips, and pieces of paper. A document from one record was located near the first door of the entrance to these back rooms. Another box of discharge records was placed by this door. In the second room,</p>	G0111	<p>G 0111-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012	

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	<p>which was behind the first room, employee files of terminated employees and patient records were found located in window sills and on the floor in no apparent order. Outside the room in the main office, a referral from File #19 was found wadded up in the trash can of Employee E, an office assistant. Documents from Patient #s 13 - 18 were found in piles in the back two rooms of the agency and on the window sill, unsecured from view of anyone who entered the room.</p> <p>2. #13 evidenced a document titled "Staff Communication Note" and signed by Employee W, Registered Nurse (RN) on 3/12/12. This document stated, "Patient #13 communication regarding supervisory visit Narrative documentation. Did supervisory visit patient today and asked about his services ... Patient was consuming alcohol at time of visit."</p> <p>3. #14 evidenced a document titled "Fax" with a date of 2/23/12 with a sticky note on top of the record which stated, "Patient #14 for D/C file not most recent file her 8/3/11 SOC [start of care]chart and Employee E signature." This document stated, "Patient #14 9/29/11 Recertify home health cert ... Parkinson's, Incontinence, R/O UTI [rule out urinary tract infection] Bedbound, Prone to skin</p>			

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	<p>breakdown ... " This was signed by Employee P on 2/23/12.</p> <p>4. #15 evidenced a document titled "Care Summary including Oasis elements for transfer to inpatient facility" with a date of 8/15/11 and signed by Employee L. This document had a sticky note on top that stated, "D/C [discharge] done." This document stated, "Reason for hospitalization Respiratory infection."</p> <p>5. #16 evidenced a document titled "Oasis Care Summary including Oasis element for transfer to inpatient facility" and dated, "8/7/11 and signed by Employee P, RN. This document stated, "Clinical record items ... Pt up to BP [infers with bathroom or blood pressure] got dizzy, weak, 911 called. Pt with cardiac blockage 3 stents placed MI [myocardial infarction] noted Pt [patient] transferred to hospice care."</p> <p>6. #17 evidenced a document titled "Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 8/8/11 and signed by employee X stated, "Clinical record items ... Reason for admission to home health and summary of care to date pneumonia, HTN [hypertension] and incontinent."</p> <p>7. #18 evidenced a document titled</p>						

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	<p>"Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 6/25/11 and signed by employee P stated, "Clinical record items ... Reason for admission Patient back from LPH [Laporte Hospital] 6/24/11 This pt saw for ROC [resumption of care] 6/25/11 increased wheezing [SOB] confusion Dr. instructed pt. to ER agreed consider hospice referral. Family switching to VNA HHC [Visiting Nurse Association home health care] for easier transition to hospice past d/c LPH."</p> <p>8. #19 evidenced a document titled, "Fax" with the signature of Employee C, director of nursing, and date of 6/7/12 date. This document stated, "Patient #19 and patient's birth date. Skilled nurse to evaluate home health care services."</p> <p>9. On 6/15/12 at 10 AM, the administrator indicated the records above were not kept confidential.</p> <p>10. The agency policy titled "Clinical record confidentiality" with an effective date of 4/31/07 stated, "Clinical records will be stored in a locked cabinet or room. When in use, the record will be kept in a secure area and not left unattended in areas accessible to unauthorized individuals."</p>						

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	<p>11. The agency policy titled "Patient security and privacy" with an effective date of 4/30/07 stated, "Patient records and protected health information will be maintained in clinical records and on computers as needed."</p> <p>12. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p style="padding-left: 40px;">a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p style="padding-left: 40px;">b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p style="padding-left: 40px;">c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p>						

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G0116	<p>484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.</p> <p>Based on clinical record review, policy and document review, and interview, the agency failed to ensure the patient /patient's power of attorney had been informed of the state hotline number for 1 of 12 clinical records (Clinical record #10) reviewed with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of</p>	G0116	<p>G 0116-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure</p>	07/18/2012			

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	<p>Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or</p>		the deficiency is corrected and will continue to monitor so it does not recur in the future.				

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	her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity ... To be informed of the toll-free state hotline."			

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G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on clinical record review, policy review and interview, the agency failed to ensure it had followed its own policies regarding the incident log and infection control for 4 of 12 records reviewed with the potential to affect all the agency's patients (patient 2, 4, 10, 12).</p> <p>Findings</p> <p>Regarding incident reports and fall prevention policy</p> <p>1. The agency policy titled "Incident Log" with a date of 4/30/07 stated, "The incident report form is to be completed whenever there is an incident involving a staff member or patient."</p> <p>2. Clinical record #2, start of care (SOC) 4/12/12 with a certification period of 4/19/12 - 6/17/12, noted falls on 5/25/12, 5/29/12, 6/1/12, 6/12/12, and 6/13/12 with no incident reports completed for any of these falls. This was evidenced by the following:</p>	G0121	G 0121 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and the Home Health Hotline number will be given upon admission. The Administrator and DON will have a care coordination plan for fall occurances between the assisted living facilities and the agency. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>a. The clinical document titled "In Home Log" with staff visits noted and vitals noted on 4/19/12, 4/23/12, 4/24/12, and 6/8/12 stated, "5/29/12 bruising R [right] shoulder 10 cm [centimeter] no signature present ... 6/4/12 with the initials of [Employee S], RN [Registered Nurse] stated, "c/o [complains of] tired keep falling."</p> <p>b. The clinical document titled "Assisted Living Facility [ALF] Fax" Re [Patient #2]" with a date of 5/25/12 stated, "Staff noted Res [resident] R area more swollen, light reddened purple area, res denies falling or hitting arm / shoulder area ... Does complain of pain to R shoulder area. Can we get portable x-ray of R shoulder area? "</p> <p>c. The clinical document titled "[Assisted Living Facility] Fax: Re: [patient #2]" with a date of 5/28/12 and addressed to agency and physician stated, "Unsafe to leave unassisted Neuromuscular Forgetful, weakness, unsteady gait, Pain yes with ROM [range of motion] Location R arm intermittent intensity 2 - 3 (0 - 10) has pain throughout body ... Found on floor on buttocks near kitchen sink. No apparent injury. Refuses to go to LPH [LaPorte Hospital] for eval [evaluation] et [and] tx</p>						

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	<p>[treatment] ... R shoulder red et swollen for several days ... " No signature appeared on this document.</p> <p>d. The clinical document titled "Skilled Nursing Note" with a date of 6/1/12 and signature of Employee L, RN stated, "Unsafe to leave unassisted Neuromuscular forgetful, weakness, unsteady gait, Pain yes with ROM ... report of fall Yes, complete incident report few days ago ... bruising R shoulder 10 cm."</p> <p>e. The clinical document titled "Skilled Nursing Note" with a date of 6/1/12 and signature of Employee L, RN stated, "Unsafe to leave unassisted Neuromuscular Forgetful, weakness, unsteady gait, Pain yes with ROM Location R intermittent intensity 2 - 3 (0 - 10) has pain throughout body ... Sling in place to immobilize R arm fingers warm pink rapid cap refill. Bruise R shoulder 13 cm [centimeter] X 10 cm yellow color edges Dr [doctor] on to immobilize until Dr Orthopod [orthopedic surgeon] VS [vital signs] for evaluation. Instructed patient on pain management ... "</p> <p>f. The clinical document titled "Staff Communication Note" with a date of 6/1/12 and signature of Employee L</p>						

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	<p>stated, "Fall c [with] injury ... Dr. notified of decreased ROM immobilize pt to dominant side Was not able to get order for any therapy at this time. Dr. office states he is scheduled to see orthopod and will not order any therapists until that time."</p> <p>g. The ALF document titled, "Short term monitor / Change of condition report" with a date of 6/1/12 and signed by RN at ALF stated, "Reeducated on call system. Educated to sleep closer to wall side of bed. Use call light, staff for all transfers. Called POA [power of attorney] asked them about getting a self release side rail ... Incare Home care notified."</p> <p>g. The clinical document titled "[Assisted Living Facility] Fax: Re [Patient #2]" with a date of 6/2/12 and no signature stated, "Found on buttocks at bedside this AM. No apparent injury ... "</p> <p>h. The clinical document titled "[Assisted Living Facility] Fax Re: Patient #2" with a date of 6/4/12 and no signature stated, "Found on floor. Skin tears to R heel, L [left] ear, L elbow, and L knee. Refusing to go to ER [emergency room] for evaluation."</p> <p>i. The clinical document titled</p>				

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	<p>"Skilled Nursing Note" with a date of 6/5/12 and signed by Employee L stated, "Unsafe to leave unassisted ... unsteady gait ... right shoulder pain .. states has not been wearing R arm immobilizer."</p> <p>j. The clinical document titled "Occupational Therapy Initial Evaluation" dated on 6/8/12 and completed by Employee M, occupational therapist, stated, "History of injury / chief complaint (reason for referral) pt referred post several falls in past weeks paid CG's [caregiver] and family report that pt is requiring significantly more assistance of paid CG then prior to falls ... pt has resided in ALF for 1 year: pt, family, staff report pt was able to I [independently] dress, groom, toilet, and bathe self until recently experiencing several falls in his apt [apartment] ... ALF staff nurse reports R humeral fx [fracture] present."</p> <p>k. The document from the Assisted living facility titled "Short term monitor / change of condition report" with a date of 6/11/12 stated, "Found on back near bedside abrasion to R side forehead. Inhouse status. Reeducated on call system. Educated to sleep closer to wall side of bed. Use call light, staff for all transfers, called poa [power of attorney] asked about getting a self release side rail."</p>			

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	<p>Incare Home Care notified."</p> <p>1. The clinical document titled "Oasis Summary including Oasis elements" with a date of 6/14/12 and signature of Employee L stated, "This assessment is currently being completed for the following reason: Transferred to an inpatient facility - patient discharged from agency. Patient condition has declined, more lethargic, weakness and falls with injury."</p> <p>m. The clinical document titled "Fax" with a date of 6/14/12 and signature of Employee L stated, "Transfer / discharge from Incare Home health services: Transfer to hospice." This was a verbal order to the Patient #2's physician.</p> <p>n. On 6/15/12 at 1:50 PM, the director of nursing indicated none of these incidents had been entered on to the incident log. After the home observation, a discharge / transfer oasis was completed and the patient was transferred to hospice care.</p> <p>3. Clinical record #4, SOC 2/1/12 with a certification period of 4/1/12 - 5/30/12. failed to evidence a incident report was completed after patient returned from hospitalization after a fall that resulted in subdural hematoma. This was evidenced</p>						

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	<p>as follows:</p> <p>a. A clinical document titled "Fall Occurrence Report" and signed by Employee L on 4/27/12 stated, "Date of fall 4/27/12 reported by ALF RN, location of fall in Settler's House Room, Witnessed by aide - Settlers, Reported to [Employee L], Contributing factors poor decision making, Details of fall: what was the patient trying to do? Get up from chair ... physical therapy to eval .. notification given to DON, PT, POC [plan of care] reviewed." This was signed by the physician on 5/4/12.</p> <p>b. A clinical document titled "Skilled Nursing Note" and dated on 5/7/12 by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... Blood Pressure 160/76 ... States he was reaching for a shirt and fell few days ago. No apparent injury noted. Denies any pain. Instructed pt on home safety and emergency precautions."</p> <p>c. A clinical document titled "Care summary including oasis elements for transfer to inpatient facility" with Employee L's signature and date of 5/8/12 stated, "Emergent care injury caused by fall ... to which inpatient facility has the</p>			

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	<p>patient been admitted Hospital ... Reason for hospitalization 2 injury caused by fall date of last visit 5/7/12 ... reported from Settlers House pt fell while trying to get up ... patient tried to transfer without assistance."</p> <p>d. A clinical document titled " Hospital Physician Orders Patient transfer order form" was dated 5/11/12 and signed by the physician." The faxed cover sheet of this document was written to Incare on 5/11/12 from a ALF nurse and stated, "Readmit."</p> <p>e. A clinical document titled "Skilled Nursing Addendum" with a signature of Employee L on 5/12/12 stated, "head to toe assessment conducted. Pt has small hematoma on posterior head which he has no c/o [complaints of] pain. Has weakness in legs and requires assistance c transfers. Uses walker with supervision and wheelchair for long distances for safety. Alarm attached to cord for altered of fall prevention. Has some difficulty with speech. Speaks very little and answers questions with few words ... Dr. notified of assessment conducted. No new orders."</p> <p>f. A clinical document titled "Skilled Nursing Note" and dated on 5/16/12 and signed by Employee L and the patient</p>				

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	<p>stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... fall prevention cord attached clothing ... incont [incontinent] care ... Fall prevention alarm cord attached clothing ... States his / her legs still feel weak. Speaks very little only answers c a few words. Instructed pt on Prozac use, action, se [side effects] Instructed pt on safety measures, fall prevention, how to call for help."</p> <p>g. The clinical document titled "Occupational Therapy Initial evaluation" with a signature of Employee V, OT on 5/16/12 stated, "Patient name #4 ... Treatment diagnosis functional decline ... decreased strength and balance to complete ADLs [Activities of Daily Living.]"</p> <p>h. A clinical document titled "Skilled Nursing Note" and dated on 5/21/12 and signed by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... fall prevention cord attached clothing ... incont [incontinent] care."</p> <p>Regarding Infection Control Log</p>						

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	<p>4. The agency policy titled "Infection Control Surveillance" with an effective date of 4/30/07 stated, "An infection control log will be maintained."</p> <p>5. On 6/15/12 at 10:50 AM, the administrator indicated there was no infection control log.</p> <p>6. Clinical record #10, SOC 12/2/11 with a certification period of 3/31/12 - 5/29/12, included keflex 500 mg [milligram] po [by mouth] bid [twice a day] x 7 days on the medication profile dated 1/30/12. This antibiotic was listed as beginning on 1/30/12. There was no documentation in the infection log regarding this antibiotic.</p> <p>7. Clinical record #12, SOC 1/12/12 with a certification period of 3/12/12 - 5/10/12, included an order for Cipro 500 mg bid X 14 days from a physician's office. There was no documentation in the infection log regarding this antibiotic.</p>						

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G0133	<p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.</p> <p>Based on policy review, administrative document review, observation, personnel file review, and interview, the administrator failed to organize and direct the agency's ongoing functions for 1 of 1 home health agency the administrator was responsible for with the potential to affect all the patients of the agency.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. The administrator failed to ensure patient rights were provided to all patient's and/or patient's power of attorney and clinical records were kept confidential. (See G 100, G 101, G 102, G 103, G 104, G 105, G 106, G 107, G 108, G 109, G 110, G 111, G 116). 2. The administrator failed to ensure it had followed its own policies regarding the incident log and infection control (See G 121). 3. The administrator failed to ensure professional staff attended inservices and 	G0133	<p>G 0133 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and confidentially and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin that is placed in a bin for shredding. The Administrator and DON have inserviced staff on completing incident reports to ensure every patient fall/incident is documented and kept in the fall occurrence log maintained by the agency. The Administrator and DON have developed an infection control log tool to ensure all infections are properly documented and monitored. This log will be maintained at the agency by the</p>	07/18/2012	

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	<p>had annual performance evaluations (See G 134).</p> <p>4. The administrator failed to ensure coordination of patient services occurred (See G 143).</p> <p>5. The administrator failed to ensure the home health aide (Employee K) only performed tasks included on the plan of care and that the aide was able to perform (See G 158).</p> <p>6. The administrator failed to ensure the plan of care included a timely physician signature (See G 159).</p> <p>7. The administrator failed to ensure the registered nurse completed a comprehensive assessment to reevaluate the patient's needs after the patient returned home after hospitalization. (See G 172)</p> <p>8. The administrator failed to ensure the registered nurse maintained effective care coordination and informed the physician of changes in patient condition. (See G 176)</p> <p>9. The administrator failed to ensure 1 of 1 contract occupational therapist evaluated the patient's level of function after falls and complaints of pain. (See</p>		<p>DON. The Administrator and DON have developed a tentative inservice schedule to ensure all professional staff attend all necessary inservices and to ensure the Aides have 12 hours of inservice education per year. The Administrator and DON have developed a tool to ensure performance evaluations are done for agencies employees on an annual basis. The Administrator and DON have inserviced staff on following the plan of care to ensure coordination of patient services occurs and that all staff are performing the appropriate tasks in which they are qualified to perform. The physician will be notified of any changes regarding treatment and/or changes in the patient condition and a verbal order will be obtained. The agency will continue with it's policy on clinical record review to ensure the plan of care is being followed and to ensure a timely physician signature is obtained. The Administrator and DON will make sure that the Registered Nurse will make a head to toe assessment after the patient has returned home from a hospitalization. The Administrator and DON have developed a plan and put into place this plan to ensure transmittal of oasis data is completed in the appropriate time frame allowed. The Administrator and DON has inserviced clinical staff on completing the</p>		

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	<p>186)</p> <p>10. The administrator failed to ensure home health aides hired prior to 1/1/12 attended any hours of inservice in 2011. (See G 215).</p> <p>11. The administrator failed to ensure clinical records were maintained in accordance to professional standards. (See G 236)</p> <p>12. The administrator failed to ensure clinical records were safeguarded against unauthorized use. (See G 239)</p> <p>13. The administrator failed to ensure a transfer assessment was transmitted. (See 324)</p> <p>14. The administrator failed to ensure the medication profile was accurate. (See G 337,</p> <p>15. The administrator failed to ensure a comprehensive assessment was completed due to a major decline in the patient's health status. (See G 338)</p> <p>16. The administrator failed to ensure a comprehensive assessment was completed after the patient returned home after hospitalization. (See G 340)</p>		<p>medication profile and updating the medication profile not only every 60 days, but during the 60 day episode if any medication changes shall occur. The Administrator and DON will make sure that services will be done regarding the comprehensive assessment including administering the oasis to the staff members. All hospitalizations for patients will be tracked so that transfers and resumptions can be completed properly within a timely manner, entered, locked and submitted, and placed in the patients chart in a timely manner. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>		

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G0134	<p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.</p> <p>Based on interview and review of personnel files and policy, the agency failed to ensure 11 of 11 staff member files reviewed of staff (files A, B, C, F, H I, J, K, L, P, and Q) hired prior to 6/12/11 had performance evaluations completed and 13 of 13 direct care employees hired prior to January 1, 2012, attended professional inservices (C, F, G, H, I, J, K, L, N, P, Q, R, and T) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. On 6/28/12 at 2:45 PM the administrator indicated no inservices had been held in 2012 or 2011 with any personnel and no performance evaluations were completed in 2011 and 2012.</p> <p>2. The agency policy titled "Inservice Education /Staff Development" with an effective date of 4/30/07 stated, "All staff members providing direct client care will attend in-service education programs annually. These programs will be based on identified staff needs."</p>	G0134	G 0134 - The Administrator and DON have developed a inservice schedule to ensure all neccessary inservices and to ensure the Aides have 12 hours of inservice education per year. The Administrator and DON have developed a tool to ensure performance evaluations are done for agencies employees on an annual basis which includes Physical Therapists, Occupational Therapistsand Speech Therapists and ensure the job description of each discipline. The Administrator and DON will be responsible to ensure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012

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	<p>3. The agency policy titled "Performance Evaluations" with an effective date of 4/30/07 stated, "A competency - based performance evaluation will be conducted for all employees after one year of employment and least annually thereafter."</p> <p>Personnel files lacking annual performance evaluations</p> <p>4. Personnel file A, date of hire (DOH) 2/5/09, lacked an annual performance evaluation.</p> <p>5. Personnel file B, DOH 2/19/09, lacked an annual performance evaluation.</p> <p>6. Personnel file C, DOH 7/19/10, lacked an annual performance evaluation.</p> <p>7. Personnel file F, DOH 11/9/08, lacked an annual performance evaluation.</p> <p>8. Personnel file H DOH 10/18/10, lacked an annual performance evaluation.</p> <p>9. Personnel file I, DOH 10/18/10, lacked an annual performance evaluation.</p> <p>10. Personnel file J, DOH 2/21/11, lacked an annual performance evaluation.</p> <p>11. Personnel file K, DOH 8/23/08,</p>						

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	<p>lacked an annual performance evaluation.</p> <p>12. Personnel file L, DOH 2/23/11, lacked an annual performance evaluation.</p> <p>13. Personnel file P DOH 4/1/09, lacked an annual performance evaluation.</p> <p>14. Personnel file Q, DOH 9/17/09, lacked an annual performance evaluation.</p> <p>Personnel files lacking inservice documentation</p> <p>15. Personnel file C, DOH 7/9/10, lacked documentation that the employee attended any inservices in 2011.</p> <p>16. Personnel file F, DOH 11/9/08, lacked documentation that the employee attended any inservices in 2011.</p> <p>17. Personnel file G, DOH 10/19/11, lacked documentation that the employee attended any inservices in 2011.</p> <p>18. Personnel file H, DOH 10/18/10, lacked documentation that the employee attended any inservices in 2011.</p> <p>19. Personnel file I, DOH 10/18/10, lacked documentation that the employee attended any inservices in 2011.</p>				

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	20. Personnel file J, DOH 2/21/11, lacked documentation that the employee attended any inservices in 2011.			
	21. Personnel file K, DOH 8/23/08, lacked documentation that the employee attended any inservices in 2011.			
	22. Personnel file L, DOH 2/23/11, lacked documentation that the employee attended any inservices in 2011.			
	23. Personnel file N, DOH 10/1/11, lacked documentation that the employee attended any inservices in 2011.			
	24. Personnel file P, DOH 4/1/09, lacked documentation that the employee attended any inservices in 2011.			
	25. Personnel file Q, DOH 9/17/09, lacked documentation that the employee attended any inservices in 2011.			
	26. Personnel file R, DOH 10/25/11, lacked documentation that the employee attended any inservices in 2011.			
	27. Personnel file T, DOH 10/25/11, lacked documentation that the employee attended any inservices in 2011.			

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G0143	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the personnel furnishing services implemented effective communication to promote the objectives in the plan of care for 1 of 6 patients reviewed (Clinical record #2) at home visit observations.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC) 4/19/12, included a plan of care for the certification period of 4/19/12 - 6/17/12 that failed to include an order for a wound dressing change on the left heel and coordination of care with the person changing the dressing. This was evidenced by the following:</p> <p>a. On 6/14/12 at 8 AM, Employee K, home health aide (HHA), indicated patient #2 had a dressing on the left heel for an abrasion. Employee K indicated he / she removed this dressing prior to showering the patient at HHA visits on 6/8/12 and 6/12/12. Employee K indicated the Employee L was aware of the abrasion. This patient lived in an</p>	G0143	G 0143 - The Administrator and DON have inserviced staff on following the plan of care to ensure coordination of patient services occurs and that all staff are performing the appropriate tasks in which they are qualified to perform. The physician will be notified of any changes regarding treatment and/or changes in the patient condition and a verbal order will be obtained. The agency will continue with it's policy on clinical record review to ensure the plan of care is being followed and to ensure a timely physician signature is obtained. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012

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	<p>assisted living and an assisted living nurse was changing this dressing.</p> <p>b. Clinical record #2 failed to indicate orders for the left heel dressing or any documentation concerning the left heel wound or dressing or a record that the dressing change was being done by the assisted living. The occurrence of the dressing removal by the aide was also not documented in the patient's clinical record or included on the aide care plan.</p> <p>2. The agency policy titled "Plan of Care" with an effective date of 4/30/07 stated, "An individualized Plan of Care signed by the physician shall be required for each patient receiving home health and personal care services. The Plan of Care shall be completed in full to include ... medications, treatments, and procedures ... all of the above items must always be addressed on the Plan of Care."</p> <p>3. The agency policy titled "Coordination of Patient services" with an effective date of 4/30/07 stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current Care plans and written and verbal</p>			

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	<p>interaction ... Interdisciplinary care conferences shall be conducted as often as necessary to respond to changes in the patient's needs, services, care, or goals ... Ongoing care conferences shall be conducted to evaluate the patient's status and progress. Any problems will be discussed and an action plan developed."</p> <p>4. On 6/15/12 at 1:50 PM, Employee C, the director of nursing, indicated the dressing and dressing removal were not included on the plan of care or included in coordination of care notes or other clinical documentation.</p>			

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G0158	<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 interview, clinical record review, and policy review, the agency failed to ensure the home health aide (Employee K) only performed tasks included on the plan of care and that the aide was able to perform for 1 of 9 active clinical records reviewed (Clinical record #2) with home health aide services.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC) 4/19/12, included a plan of care for the certification period of 4/19/12 - 6/17/12 that failed to include an order for a wound dressing change on the left heel.</p> <p>a. On 6/14/12 at 8 AM, Employee K, home health aide (HHA), indicated patient #2 had a dressing on the left heel for an abrasion. Employee K indicated he / she removed this dressing prior to showering the patient at HHA visit on 6/8/12 and 6/12/12. This patient lived in an assisted living and an assisted living nurse was changing this dressing. Employee K indicated the Employee L, registered nurse, was aware of the</p>	G0158	G 0158 - The Administrator and DON have inserviced staff on following the plan of care to ensure coordination of patient services occurs and that all staff are performing the appropriate tasks within their orientation and job description in which they are qualified to perform. The physician will be notified of any changes regarding treatment and/or changes in the patient condition and a verbal order will be obtained. The agency will continue with it's policy on clinical record review to ensure the plan of care is being followed and to ensure a timely physician signature is obtained. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012

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	<p>abrasion.</p> <p>b. Clinical record #2 failed to include orders for the left heel dressing or any documentation concerning the left heel wound or dressing.</p> <p>2. The agency policy titled "Plan of Care" with an effective date of 4/30/07 stated, "An individualized Plan of Care signed by the physician shall be required for each patient receiving home health and personal care services. The Plan of Care shall be completed in full to include ... medications, treatments, and procedures ... all of the above items must always be addressed on the Plan of Care."</p> <p>3. On 6/15/12 at 1:50 PM, Employee C, the director of nursing, indicated the dressing and dressing removal were not included on the plan of care.</p>				

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G0159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care included a timely physician signature for 4 of 12 records reviewed (clinical record #1, #4, #7, and #11) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care (SOC) 1/12/12, included a plan of care for the certification period of 5/11/12 - 7/9/12 that failed to evidence a timely physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home health Certification and Plan of treatment" with a certification period of 5/11/12 - 7/9/12 was not signed by the physician.</p>	G0159	G 0159 - The Administrator and DON have inserviced staff on following the plan of care to ensure coordination of patient services occurs and that all staff are performing the appropriate tasks within their orientation and job description in which they are qualified to perform. The physician will be notified of any changes regarding treatment and/or changes in the patient condition and a verbal order will be obtained. The agency will continue with it's policy on clinical record review to ensure the plan of care is being followed and to ensure a timely physician signature is obtained. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>b. On 6/13/12 at 11:55 AM, Employee C, the director of nursing (DON), indicated the physician signature was not present.</p> <p>2. Clinical record #4, SOC 2/1/12, included a plan of care for the certification period of 4/1/12 - 5/30/12 that failed to evidence a timely physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home health Certification and Plan of treatment" with a certification period of 4/1/12 - 5/30/12 was not signed by the physician.</p> <p>b. On 6/14/12 at 3:20 PM, Employee C indicated the physician signature was not present.</p> <p>3. Clinical record #7, SOC 9/29/11, included a plan of care for the certification period of 1/27/12 - 3/26/12 failed to evidence a timely physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home health Certification and Plan of treatment" with a certification period of 1/27/12 - 3/26/12 was signed by the physician on 3/9/12.</p>			

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	<p>b. On 6/18/12 at 11 AM, Employee C indicated the physician signature was late.</p> <p>4. Clinical record #11, SOC 4/25/12, included a plan of care for the certification period of 4/25/12 - 6/23/12 that failed to evidence a physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home health Certification and Plan of treatment" with a certification period of 4/25/12 - 6/23/12 was not signed by the physician.</p> <p>b. On 6/13/12 at 12:40 PM, Employee S indicated the physician signature was not present.</p> <p>5. The agency policy titled "Physician Orders" with an effective date of 4/30/12 stated, "All medications, treatments, and services provided to patients must be ordered by a physician the orders must be initiated via telephone or in writing and must be countersigned by the physician in a timely manner ... A system will be used by the agency to ensure the telephone orders are signed and dated by the physician and returned to the patient's clinical record within appropriate time frame."</p>						

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	6. The agency policy titled "Plan of care" with an effective date of 4/30/12 stated, "An individual Plan of care signed by a physician shall be required for each patient receiving home health and personal care services ... The written Plan of Care shall be signed by the physician and returned to the agency ... Signed physician orders will be obtained as quickly as possible."			

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G0172	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>Based on clinical record review, document review, interview, and policy review, the agency failed to ensure the registered nurse completed a comprehensive assessment to reevaluate the patient's needs after the patient returned home after hospitalization for 1 of 6 home visit observations (Clinical record #4.)</p> <p>Findings</p> <p>1. Clinical record #4, SOC 2/1/12 with a certification period of 4/1/12 - 5/30/12. failed to evidence a comprehensive assessment was completed when the patient returned from hospitalization after a fall that resulted in subdural hematoma. This was evidenced as follows:</p> <p>a. A clinical document titled "Fall Occurrence Report" and signed by Employee L on 4/27/12 stated, "Date of fall 4/27/12 reported by ALF RN, location of fall in Settler's House Room, Witnessed by aide - Settlers, Reported to [Employee L], Contributing factors poor decision making, Details of fall: what was</p>	G0172	G 0172 - All hospitalizations for patients will be tracked so that transfers and resumptions can be completed properly within a timely manner, entered, locked and submitted, and placed in the patients chart in a timely manner. The Administrator and DON will make a policy that the nurse will make a head to toe assessment done after the patient returns home after a hospitization. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012	

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	<p>the patient trying to do? Get up from chair ... physical therapy to eval .. notification given to DON, PT, POC [plan of care] reviewed." This was signed by the physician on 5/4/12.</p> <p>b. A clinical document titled "Skilled Nursing Note" and dated on 5/7/12 by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... Blood Pressure 160/76 ... States he was reaching for a shirt and fell few days ago. No apparent injury noted. Denies any pain. Instructed pt on home safety and emergency precautions."</p> <p>c. A clinical document titled "Care summary including oasis elements for transfer to inpatient facility" with Employee L's signature and date of 5/8/12 stated, "Emergent care injury caused by fall ... to which inpatient facility has the patient been admitted Hospital ... Reason for hospitalization 2 injury caused by fall date of last visit 5/7/12 ... reported from Settlers House pt fell while trying to get up ... patient tried to transfer without assistance."</p> <p>d. A clinical document titled "Hospital Physician Orders Patient transfer order form" was dated 5/11/12 and signed</p>				

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	<p>by the physician." The faxed cover sheet of this document was written to Incare on 5/11/12 from a ALF nurse and stated, "Readmit."</p> <p>e. A clinical document titled "Skilled Nursing Addendum" with a signature of Employee L on 5/12/12 stated, "head to toe assessment conducted. Pt has small hematoma on posterior head which he has no c/o [complaints of] pain. Has weakness in legs and requires assistance c transfers. Uses walker with supervision and wheelchair for long distances for safety. Alarm attached to cord for altered of fall prevention. Has some difficulty with speech. Speaks very little and answers questions with few words ... Dr. notified of assessment conducted. No new orders."</p> <p>f. A clinical document titled "Skilled Nursing Note" and dated on 5/16/12 and signed by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... fall prevention cord attached clothing ... incont [incontinent] care ... Fall prevention alarm cord attached clothing ... States his / her legs still feel weak. Speaks very little only answers c a few words. Instructed pt on Prozac use, action, se [side effects] Instructed pt on</p>						

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	<p>safety measures, fall prevention, how to call for help."</p> <p>g. The clinical document titled "Occupational Therapy Initial evaluation" with a signature of Employee V, OT on 5/16/12 stated, "Patient name #4 ... Treatment diagnosis functional decline ... decreased strength and balance to complete ADLs [Activities of Daily Living.]"</p> <p>h. A clinical document titled "Skilled Nursing Note" and dated on 5/21/12 and signed by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... fall prevention cord attached clothing ... incont [incontinent] care."</p> <p>2. The agency policy titled "Comprehensive Patient Assessment" with an effective date of 4/30/07 stated, "To determine the appropriate care, treatment and services to meet patient initial needs and his/her changing needs ... Reassessments are conducted based on patient needs, physician orders, professional judgement or other regulatory requirement."</p>						

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G0176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on home visit observation, clinical record review, interview and policy, the agency failed to ensure the registered nurse (Employee L) maintained effective care coordination and informed the physician of changes in patient condition for 1 of 6 patients reviewed (Clinical record #2) at home visit observations.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC) 4/19/12, included a plan of care for the certification period of 4/19/12 - 6/17/12 that failed to include an order for a wound dressing change on the left heel and coordination of care for this treatment. This was evidenced by the following:</p> <p>On 6/14/12 at 8 AM, Employee K, home health aide (HHA), indicated patient #2 had a dressing on the left heel for an abrasion to the left heel. Employee K indicated he / she removed this dressing prior to showering the patient at HHA visits on 6/8/12 and 6/12/12. Employee K indicated the Employee L, Registered Nurse, was aware of the abrasion. This patient lived in an assisted living and an</p>	G0176	G 0176 - The Administrator and DON will make sure the Registered Nurse should make doctors order for wound care / dressing and do care coordination for any treatment done to any patient. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>assisted living nurse was changing this dressing. The record failed to evidence any communication with the nurse providing the dressing change or that the physician had been notified of the abrasion.</p> <p>2. The agency policy titled "Plan of Care" with an effective date of 4/30/07 stated, "An individualized Plan of Care signed by the physician shall be required for each patient receiving home health and personal care services. The Plan of Care shall be completed in full to include ... medications, treatments, and procedures ... all of the above items must always be addressed on the Plan of Care."</p> <p>3. The agency policy titled "Coordination of Patient services" with an effective date of 4/30/07 stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current Care plans and written and verbal interaction ... Interdisciplinary care conferences shall be conducted as often as necessary to respond to changes in the patient's needs, services, care, or goals ... Ongoing care conferences shall be conducted to evaluate the patient's status</p>				

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	<p>and progress. Any problems will be discussed and an action plan developed."</p> <p>4. On 6/15/12 at 1:50 PM, Employee C, the director of nursing, indicated the dressing and dressing removal were not included on the plan of care or included in coordination of care notes or other clinical documentation. The physician had not been notified of the abrasion.</p>			

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G0186	<p>484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.)</p> <p>Based on home visit observation, policy review, and interview, the agency failed to ensure 1 of 1 contract occupational therapist (Employee M) evaluated the patient's level of function after falls and complaints of pain for 1 of 6 records reviewed of patients receiving occupational therapy (OT) services (patient #2) with the potential to affect all the agency's patient who received OT services.</p> <p>Findings include:</p> <p>1. On 6/13/12 at 4 PM, Employee M, occupational therapist, was observed at a occupational therapy visit with patient #2. This patient lived at an assisted living facility. Patient indicated had two falls in past two days (6/12/12 and 6/13/12) as patient was transferring from bed to wheelchair. Patient had a bruise on left cheek and left buttocks area that was visible between the shirt and pants worn and also painful knees. The occupational therapist did not do a skin assessment or other physical assessment before preceding to an observation of the patient's skills with transferring from</p>	G0186	G 0186 - The Administrator and DON will implement annual evaluation to the different agencies which involve the services of Occupational Therapists to evaluate there competencies and skills. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>recliner to wheelchair to bed despite the patient's complaints of pain in knees and bruising noted.</p> <p>2. The agency policy titled "Position: Occupational Therapist" with an effective date of 4/07 stated, "Provides services to home care clients in accordance with the Plan of Care. Services are provided under the direction of the attending physician with participation of the family and other members of the interdisciplinary team, as indicated ... Essential Functions/Areas of Accountability 1. Performs occupational therapy assessments, diagnostic tests, skilled treatments, and ongoing evaluation of clients who are receiving services under a medically approved Plan of Care. a. completes assessments in a timely manner and in accordance with Agency Policy ... c. Provides assessment findings and goals to assist in developing the client care plan and obtains specific physician orders as needed."</p> <p>3. On 6/15/12 at 1:50 PM, Employee C, the director of nursing indicated the occupational therapist did not evaluate the patient despite the patient's complaints of pain and bruising noted and report of additional falls on 6/12 and 6/13/12.</p>						

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G0215	<p>484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient.</p> <p>Based on interview, document review, personnel file review, and policy review, the agency failed to ensure 3 of 3 home health aides hired prior to 1/1/12 (files F, K, and R) attended any hours of inservice in 2011.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence any home health aide in service training had been conducted. 2. Personnel files F, date of hire (DOH 11/9/08), K DOH 8/23/08, and R DOH 10/25/11 failed to evidence any inservice education had been completed. 3. On 6/28/12 at 2:45 PM, the administrator indicated no inservices had been held in 2012 or 2011 with any personnel. 4. The agency policy titled "Inservice Education /Staff Development" with an effective date of 4/30/07 stated, "All staff members providing direct client care will 	G0215	G 0215 - The Administrator and DON have developed a tentative inservice schedule to ensure all neccessary inservices and to ensure the Aides have 12 hours of inservice education per year. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	attend in-service education programs annually. These programs will be based on identified staff needs."			

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G0236	<p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review, document review, observation, and interview, the agency failed to ensure clinical records were maintained in accordance to professional standards for 5 of 12 records reviewed (Clinical record #2 -5 and 11) and 6 of 6 former patient records (#13 - 18) and 1 of 1 potential patient document (#19) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>Regarding professional standards</p> <p>1. On 6/15/12 at 10 AM, many documents were observed in two back rooms of the agency. These documents were located in piles and singly placed around these back rooms with other debris including food wrappers, paper clips, and pieces of paper. A document</p>	G0236	G 0236 - The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and confidentially and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin that is placed in a bin for shredding. (Space will be kept clean and free of clutter). The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>from one record was located near the first door of the entrance to these back rooms. Another box of discharged records was placed by this door. In the second room which was behind the first room, patient records were located in window sills and on the floor in no apparent order. Outside the room in the main office, a referral from File #19 was found wadded up in the trash can of Employee E, an office assistant. Clinical records 13 - 18 were found in piles in the back two rooms of the agency and in the window sill.</p> <p>2. Clinical record #13 evidenced a document titled "Staff Communication Note" and signed by Employee W, Registered Nurse (RN) on 3/12/12. This document stated, "[Patient #13] communication regarding supervisory visit Narrative documentation. Did supervisory visit patient today and asked about his services ... Patient was consuming alcohol at time of visit."</p> <p>3. Clinical record #14 evidenced a document titled "Fax" with a date of 2/23/12 with a sticky note on top of the record which stated, "[Patient #14] for D/C file not most recent file her 8/3/11 SOC [start of care] chart and [Employee E's] signature." This document stated, "Patient #14 9/29/11 Recertify home health cert ... Parkinson's, Incontinence,</p>			

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	<p>R/O UTI [rule out urinary tract infection] Bedbound, Prone to skin breakdown ... " This was signed by Employee P on 2/23/12.</p> <p>4. Clinical record #15 evidenced a document titled "Care Summary including Oasis elements for transfer to inpatient facility" with a date of 8/15/11 and signed by Employee L. This document had a sticky note on top that stated, "D/C [discharge] done." This document stated, "Reason for hospitalization Respiratory infection."</p> <p>5. Clinical record #16 evidenced a document titled "Oasis Care Summary including Oasis element for transfer to inpatient facility" and dated, "8/7/11 and signed by Employee P, RN. This document stated, "Clinical record items ... Pt [patient] up to BP [infers with bathroom or blood pressure] got dizzy, weak, 911 called. Pt with cardiac blockage 3 stents placed MI [myocardial infarction] noted Pt transferred to hospice care."</p> <p>6. Clinical record #17 evidenced a document titled "Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 8/8/11 and signed by employee X stated, "Clinical record items ... Reason for</p>						

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	<p>admission to home health and summary of care to date pneumonia, HTN [hypertension] and incontinent."</p> <p>7. Clinical record #18 evidenced a document titled "Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 6/25/11 and signed by employee P stated, "Clinical record items ... Reason for admission Patient back from LPH [Laporte Hospital] 6/24/11 This pt saw for ROC [resumption of care] 6/25/11 increased wheezing [SOB] confusion Dr. instructed pt. to ER agreed consider hospice referral. Family switching to VNA HHC [Visiting Nurse Association home health care] for easier transition to hospice past d/c LPH."</p> <p>8. Clinical record #19 evidenced a document titled, "Fax" with the signature of Employee C, director of nursing and date of 6/7/12 date. This document stated, "[Patient #19] and patient's birth date. Skilled nurse to evaluate home health care services."</p> <p>9. On 6/15/12 at 10 AM, the administrator indicated the records above were not kept in accordance with professional standards.</p> <p>10. The agency policy titled "Clinical</p>						

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	<p>record confidentiality" with an effective date of 4/31/07 stated, "Clinical records will be stored in a locked cabinet or room. When in use, the record will be kept in a secure area and not left unattended in areas accessible to unauthorized individuals."</p> <p>11. The agency policy titled "Patient security and privacy" with an effective date of 4/30/07 stated, "Patient records and protected health information will be maintained in clinical records and on computers as needed."</p> <p>12. Clinical record #4, SOC 2/1/12 with a certification period 4/1/12 - 5/30/12, was missing the update to the comprehensive assessment prior to the above certification period. The missing recertification was found and placed in the clinical record. This document was dated 3/28/12 and signed by Employee L. This was evidenced by the following:</p> <p>On 6/14/12 at 3:45 PM, the director of nursing indicated the update to the comprehensive assessment was not present in the record.</p> <p>13. Clinical record #5, SOC 3/23/12 with certification periods of 3/23/12 - 5/21/12 and 5/22/12 - 7/20/12, was missing all physical and occupational therapy</p>						

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	<p>evaluations and visit notes.</p> <p>On 6/14/12 at 2:30 PM, the director of nursing indicated no physical therapy or occupational therapy visit notes or evaluations were in the clinical record. Visits and evaluations were missing from the start of care.</p> <p>14. Clinical record #11, SOC 4/25/12 with a certification period of 4/25/12 - 6/23/12, evidenced no nursing visit notes in the clinical record after 5/17/12. This was evidenced by the following:</p> <p>a. The Plan of care indicated the skilled nurse would visit once a week for 9 weeks.</p> <p>b. On 6/13/12 at 12:40 PM, the DON and administrator indicated no nursing notes were included in the clinical record.</p> <p>Regarding clinical records misfiled</p> <p>15. Clinical record #2, start of care 4/19/12 with a certification period of 2/17/12 - 4/19/12 - 6/17/12, included documents from another record. This was evidenced as follows:</p> <p>a. A clinical document titled "Steel Family Healthcare" with another patient's name and date of birth and visit date of</p>						

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	<p>2/17/12 stated, "Patient comes in today basically to kind of clarify her pain medication ..." This was signed by a physician on 2/17/12.</p> <p>b. A clinical document titled "Quest Diagnostics" with another patient's name and identifiers stated, "Renal Function Panel Glucose 91 ... 2/21/12 letter of lab order sent JB."</p> <p>c. On 6/15/12 at 2 PM, the director of nursing (DON) indicated the above documents were from another patient's clinical records.</p>			

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G0239	<p>484.48(b) PROTECTION OF RECORDS Clinical record information is safeguarded against loss or unauthorized use.</p> <p>Based on observation, interview, review of policies, and clinical documents, the agency failed to ensure clinical records were safeguarded against unauthorized use for 6 of 6 patient records not reviewed (patients' 13 - 18) and 1 of 1 potential patient record (#19) observed on the floor and in window sills of the agency with the potential to affect all the agency's patients.</p> <p>Findings include</p> <p>1. On 6/15/12 at 10 AM, many documents were observed in two back rooms of the agency. These documents were located in piles and singly placed around these back rooms with other debris including food wrappers, paper clips, and pieces of paper. A document from one record was located near the first door of the entrance to these back rooms. Another box of discharge records was placed by this door. In the second room, which was behind the first room, employee files of terminated employees and patient records were found located in window sills and on the floor in no</p>	G0239	<p>G 0239-The Administrator and DON have in-serviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit and ensure the agency will have the copy of power of attorney if the patients had one. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and file in secure, locked cabinet and not accesable by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin for shredding.The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012	

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	<p>apparent order. Outside the room in the main office, a referral from File #19 was found wadded up in the trash can of Employee E, an office assistant. Documents from Patient #s 13 - 18 were found in piles in the back two rooms of the agency and on the window sill, unsecured from view of anyone who entered the room.</p> <p>2. #13 evidenced a document titled "Staff Communication Note" and signed by Employee W, Registered Nurse (RN) on 3/12/12. This document stated, "Patient #13 communication regarding supervisory visit Narrative documentation. Did supervisory visit patient today and asked about his services ... Patient was consuming alcohol at time of visit."</p> <p>3. #14 evidenced a document titled "Fax" with a date of 2/23/12 with a sticky note on top of the record which stated, "Patient #14 for D/C file not most recent file her 8/3/11 SOC [start of care]chart and Employee E signature." This document stated, "Patient #14 9/29/11 Recertify home health cert ... Parkinson's, Incontinence, R/O UTI [rule out urinary tract infection] Bedbound, Prone to skin breakdown ... " This was signed by Employee P on 2/23/12.</p> <p>4. #15 evidenced a document titled "Care</p>						

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	<p>Summary including Oasis elements for transfer to inpatient facility" with a date of 8/15/11 and signed by Employee L. This document had a sticky note on top that stated, "D/C [discharge] done." This document stated, "Reason for hospitalization Respiratory infection."</p> <p>5. #16 evidenced a document titled "Oasis Care Summary including Oasis element for transfer to inpatient facility" and dated, "8/7/11 and signed by Employee P, RN. This document stated, "Clinical record items ... Pt up to BP [infers with bathroom or blood pressure] got dizzy, weak, 911 called. Pt with cardiac blockage 3 stents placed MI [myocardial infarction] noted Pt [patient] transferred to hospice care."</p> <p>6. #17 evidenced a document titled "Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 8/8/11 and signed by employee X stated, "Clinical record items ... Reason for admission to home health and summary of care to date pneumonia, HTN [hypertension] and incontinent."</p> <p>7. #18 evidenced a document titled "Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 6/25/11 and signed by employee P stated, "Clinical record items</p>						

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	<p>... Reason for admission Patient back from LPH [Laporte Hospital] 6/24/11 This pt saw for ROC [resumption of care] 6/25/11 increased wheezing [SOB] confusion Dr. instructed pt. to ER agreed consider hospice referral. Family switching to VNA HHC [Visiting Nurse Association home health care] for easier transition to hospice past d/c LPH."</p> <p>8. #19 evidenced a document titled, "Fax" with the signature of Employee C, director of nursing, and date of 6/7/12 date. This document stated, "Patient #19 and patient's birth date. Skilled nurse to evaluate home health care services."</p> <p>9. On 6/15/12 at 10 AM, the administrator indicated the records above were not kept confidential.</p> <p>10. The agency policy titled "Clinical record confidentiality" with an effective date of 4/31/07 stated, "Clinical records will be stored in a locked cabinet or room. When in use, the record will be kept in a secure area and not left unattended in areas accessible to unauthorized individuals."</p> <p>11. The agency policy titled "Patient security and privacy" with an effective date of 4/30/07 stated, "Patient records and protected health information will be</p>			

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	maintained in clinical records and on computers as needed."				

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G0324	<p>484.20(c)(2) TRANSMITTAL OF OASIS DATA The HHA must, for all assessments completed in the previous month, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section.</p> <p>Based on clinical record review, agency document review, interview, and policy review, the agency failed to ensure a transfer assessment was transmitted for 1 of 2 closed records reviewed (Clinical record #3) with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. Clinical record #3, start of care 12/19/11 with a certification period of 12/19/11 - 2/16/12, failed to evidence a transfer assessment to an inpatient facility. The record evidenced the patient was transferred to a hospital after an emergency room evaluation. This was evidenced by the following:</p> <p style="padding-left: 40px;">a. The clinical document titled "Oasis Summary including Oasis elements for Transfer to inpatient facility" with a date of 12/27/11 and signature of the director of nursing (DON) stated, "Transferred to an inpatient facility ... Patient had diarrhea upon visit 12/27/11 .. called up MD [doctor], MD out, called later and ordered to bring PT [patient] to ER [Emergency Room]. Called up</p>	G0324	G 0324 - The Administrator and DON have developed a plan and put into place this plan to ensure transmittal of oasis data is completed in the appropriate time frame allowed. All hospitalizations for patients will be tracked so that transfers and resumptions can be completed properly within a timely manner, entered, locked and submitted, and placed in the patients chart in a timely manner. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012	

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	<p>[caregiver] about MD's ordered. [Caregiver] called ambulance and PT since then is in the hosp [hospital]."</p> <p>b. The agency document titled "OASIS [Patient #3]" with admit dates of 12/19/11 and 5/2/12 failed to ensure the transfer / discharge oasis data was transmitted to the state.</p> <p>c. On 6/18/12 at 3:30 PM, the alternate administrator indicated the transfer assessment was not completed for patient #3.</p> <p>d. The agency was unable to produce documentation of the transfer assessment for patient #3 which had been transmitted to the state when asked on 6/18/12.</p> <p>2. The agency policy titled "Encoding and Reporting Oasis data" with an effective date of 4/30/07 stated, "The agency will electronically report all OASIS data collected in accordance with federal regulations ... To transmit assessment data on all skilled (Medicare and Medicaid) patients receiving services from Agency ... Encoding of all OASIS data must be completed (locked) to accurately complete the information necessary to send Medicare claims under the prospective payment system."</p>						

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G0337	<p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review and interview, the agency failed to ensure the medication profile was accurate for 3 of 6 home visit observations (Clinical record #1, 5, and 11) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care (SOC) 1/12/12 and a plan of care for certification period 5/11/12 - 7/9/12 , failed to evidence a medication profile had been updated with a complete list of the patient's current medications. This was evidenced by the following:</p> <p style="padding-left: 40px;">a. On 6/13/12 at 8 AM at a home visit observation, patient #1 indicated taking fish oil 1000 milligram once a day since the start of care and also increasing Bystolic 10 milligrams po (by mouth) every day per doctor's order to 20 milligrams per day in the past month.</p> <p style="padding-left: 40px;">b. A clinical document titled</p>	G0337	G 0337 - The Administrator and DON has inserviced clinical staff on completing the medication profile and updating the medication profile not only every 60 days, but during the 60 day episode if any medication changes shall occur. The Administrator and DON will do inservices on the drug regimen review and do comprehensive assessment which includes a review of all medications the patient is currently taking, the adverse effects, drug interaction, duplicate drug therapy and non-compliance with drug therapy and notify physician of any changes that occur. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>"Medication Profile" and signed by Employee N, Registered Nurse (RN), showed no additions to the medication profile since 5/9/12. Fish oil was not on the medication profile and the increase of Bystolic had not been added.</p> <p>c. On 6/13/12 at 11:50 AM, employee C, the director of nursing (DON), indicated fish oil and the increased bystolic medication were not on the medication profile.</p> <p>2. Clinical record #5, SOC 3/23/12 with a plan of care for the certification period of 5/22/12 - 7/20/12 , failed to evidence a medication profile had been updated with a complete list of the patient's current medications. This was evidenced by the following:</p> <p>a. On 6/14/12 at 11 AM at a home visit observation, patient #5 indicated Lopressor had been reduced to 25 milligrams twice a day two weeks ago.</p> <p>b. A clinical document titled "Medication Profile" and signed by Employee N, RN, showed no additional review or change to the medication profile since 5/21/12. The Medication Profile stated, "Lopressor 50 mg [milligram] po [by mouth] bid [twice a day] BP [blood pressure]."</p>						

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	<p>c. On 6/14/12 at 2:30 PM, the DON indicated the medication profile had not been updated with the patient's change of medication dosage.</p> <p>3. Clinical record #11, SOC 4/25/12 with a plan of care for the certification period of 4/25/12 - 6/23/12, failed to evidence the medication profile had been updated with a complete list of the patient's current medications with accurate dosing. This was evidenced by the following:</p> <p>a. The clinical document titled "Medication Profile" signed by Employee S, RN, stated, "4/25/12 Vasotec 20 mg 1 po bid [twice a day] ... Coumadin 5 mg 1 po Q [every] 5 PM. Blood thinner." No changes to this document had occurred since this date.</p> <p>b. The clinical document titled "Skilled Nursing Note" with a date of 5/10/12 and signature of Employee S stated, "Orders received from Dr. that increase Vasotec for B/P 170/80 in Dr. Office. Pt [patient] will be off Coumadin for next dentist visit scheduled for 12 of May so pt will be off coumadin again for readjust meds."</p> <p>c. The clinical document titled "Skilled Nursing Note" with a date of</p>				

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	<p>5/17/12 and signature of Employee S stated, "Pt recently off Coumadin for Dental Care."</p> <p>d. The clinical document titled "Fax Incare Home Healthcare Inc." with a date of 5/30/12 and signature of the physician and Employee S stated, "Take 1 1/2 (5 mg pill) x 2 days = 7.5 mg resume 5 mg p [after] redraw in one week ..."</p> <p>e. On 6/13/12 at 12:40 PM, the DON and administrator indicated no updates had been added to the medication profile.</p>				

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G0338	<p>484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status.</p> <p>Based on clinical record review, document review, interview, and policy review, the agency failed to ensure a comprehensive assessment was completed due to a major decline in the patient's health status for 1 of 6 home visit observations (Clinical record #2.)</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC) 4/12/12 with a certification period of 4/19/12 - 6/17/12, noted falls on 5/25/12, 5/29/12, 6/1/12, 6/12/12, and 6/13/12 with no assessment completed for a significant change in condition for any of these falls. This was evidenced by the following:</p> <p>a. The clinical document titled "In Home Log" with staff visits noted and vitals noted on 4/19/12, 4/23/12, 4/24/12, and 6/8/12 stated, "5/29/12 bruising R [right] shoulder 10 cm [centimeter] no signature present ... 6/4/12 with the initials of [Employee S], RN [Registered</p>	G0338	G 0338 - The Administrator and DON will make inservices be done regarding the comprehensive assessment (including the Administration of the Oasis) to all staff members and disciplines involved. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>Nurse] stated, "c/o [complains of] tired keep falling."</p> <p>b. The clinical document titled "Assisted Living Facility [ALF] Fax" Re [Patient #2]" with a date of 5/25/12 stated, "Staff noted Res [resident] R area more swollen, light reddened purple area, res denies falling or hitting arm / shoulder area ... Does complain of pain to R shoulder area. Can we get portable x-ray of R shoulder area? "</p> <p>c. The clinical document titled "[Assisted Living Facility] Fax: Re: [patient #2]" with a date of 5/28/12 and addressed to agency and physician stated, "Unsafe to leave unassisted Neuromuscular Forgetful, weakness, unsteady gait, Pain yes with ROM [range of motion] Location R arm intermittent intensity 2 - 3 (0 - 10) has pain throughout body ... Found on floor on buttocks near kitchen sink. No apparent injury. Refuses to go to LPH [LaPorte Hospital] for eval [evaluation] et [and] tx [treatment] ... R shoulder red et swollen for several days ... " No signature appeared on this document.</p> <p>d. The clinical document titled "Skilled Nursing Note" with a date of 6/1/12 and signature of Employee L, RN stated, "Unsafe to leave unassisted</p>						

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	<p>Neuromuscular forgetful, weakness, unsteady gait, Pain yes with ROM ... report of fall Yes, complete incident report few days ago ... bruising R shoulder 10 cm."</p> <p>e. The clinical document titled "Skilled Nursing Note" with a date of 6/1/12 and signature of Employee L, RN stated, "Unsafe to leave unassisted Neuromuscular Forgetful, weakness, unsteady gait, Pain yes with ROM Location R intermittent intensity 2 - 3 (0 - 10) has pain throughout body ... Sling in place to immobilize R arm fingers warm pink rapid cap refill. Bruise R shoulder 13 cm [centimeter] X 10 cm yellow color edges Dr [doctor] on to immobilize until Dr Orthopod [orthopedic surgeon] VS [vital signs] for evaluation. Instructed patient on pain management ... "</p> <p>f. The clinical document titled "Staff Communication Note" with a date of 6/1/12 and signature of Employee L stated, "Fall c [with] injury ... Dr. notified of decreased ROM immobilize pt to dominant side Was not able to get order for any therapy at this time. Dr. office states he is scheduled to see orthopod and will not order any therapists until that time."</p>						

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	<p>g. The ALF document titled, "Short term monitor / Change of condition report" with a date of 6/1/12 and signed by RN at ALF stated, "Reeducated on call system. Educated to sleep closer to wall side of bed. Use call light, staff for all transfers. Called POA [power of attorney] asked them about getting a self release side rail ... Incare Home care notified."</p> <p>g. The clinical document titled "[Assisted Living Facility] Fax: Re [Patient #2]" with a date of 6/2/12 and no signature stated, "Found on buttocks at bedside this AM. No apparent injury ... "</p> <p>h. The clinical document titled "[Assisted Living Facility] Fax Re: Patient #2" with a date of 6/4/12 and no signature stated, "Found on floor. Skin tears to R heel, L [left] ear, L elbow, and L knee. Refusing to go to ER [emergency room] for evaluation."</p> <p>i. The clinical document titled "Skilled Nursing Note" with a date of 6/5/12 and signed by Employee L stated, "Unsafe to leave unassisted ... unsteady gait ... right shoulder pain .. states has not been wearing R arm immobilizer."</p> <p>j. The clinical document titled "Occupational Therapy Initial Evaluation"</p>				

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	<p>dated on 6/8/12 and completed by Employee M, occupational therapist, stated, "History of injury / chief complaint (reason for referral) pt referred post several falls in past weeks paid CG's [caregiver] and family report that pt is requiring significantly more assistance of paid CG then prior to falls ... pt has resided in ALF for 1 year: pt, family, staff report pt was able to I [independently] dress, groom, toilet, and bathe self until recently experiencing several falls in his apt [apartment] ... ALF staff nurse reports R humeral fx [fracture] present."</p> <p>k. The document from the Assisted living facility titled "Short term monitor / change of condition report" with a date of 6/11/12 stated, "Found on back near bedside abrasion to R side forehead. Inhouse status. Reeducated on call system. Educated to sleep closer to wall side of bed. Use call light, staff for all transfers, called poa [power of attorney] asked about getting a self release side rail. Incare Home Care notified."</p> <p>l. The clinical document titled "Oasis Summary including Oasis elements" with a date of 6/14/12 and signature of Employee L stated, "This assessment is currently being completed for the following reason: Transferred to an</p>				

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	<p>inpatient facility - patient discharged from agency. Patient condition has declined, more lethargic, weakness and falls with injury."</p> <p>m. The clinical document titled "Fax" with a date of 6/14/12 and signature of Employee L stated, "Transfer / discharge from Incare Home health services: Transfer to hospice." This was a verbal order to the Patient #2's physician.</p> <p>n. On 6/15/12 at 1:50 PM, the director of nursing indicated none of these incidents had been entered on to the incident log. After the home observation, a discharge / transfer oasis was completed and the patient was transferred to hospice care.</p> <p>2. Clinical record #4, SOC 2/1/12 with a certification period of 4/1/12 - 5/30/12. failed to evidence a incident report was completed after patient returned from hospitalization after a fall that resulted in subdural hematoma. This was evidenced as follows:</p> <p>a. A clinical document titled "Fall Occurrence Report" and signed by Employee L on 4/27/12 stated, "Date of fall 4/27/12 reported by ALF RN, location of fall in Settler's House Room, Witnessed by aide - Settlers, Reported to</p>			

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	<p>[Employee L], Contributing factors poor decision making, Details of fall: what was the patient trying to do? Get up from chair ... physical therapy to eval .. notification given to DON, PT, POC [plan of care] reviewed." This was signed by the physician on 5/4/12.</p> <p>b. A clinical document titled "Skilled Nursing Note" and dated on 5/7/12 by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... Blood Pressure 160/76 ... States he was reaching for a shirt and fell few days ago. No apparent injury noted. Denies any pain. Instructed pt on home safety and emergency precautions."</p> <p>c. A clinical document titled "Care summary including oasis elements for transfer to inpatient facility" with Employee L's signature and date of 5/8/12 stated, "Emergent care injury caused by fall ... to which inpatient facility has the patient been admitted Hospital ... Reason for hospitalization 2 injury caused by fall date of last visit 5/7/12 ... reported from Settlers House pt fell while trying to get up ... patient tried to transfer without assistance."</p> <p>d. A clinical document titled "</p>						

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	<p>Hospital Physician Orders Patient transfer order form" was dated 5/11/12 and signed by the physician." The faxed cover sheet of this document was written to Incare on 5/11/12 from a ALF nurse and stated, "Readmit."</p> <p>e. A clinical document titled "Skilled Nursing Addendum" with a signature of Employee L on 5/12/12 stated, "head to toe assessment conducted. Pt has small hematoma on posterior head which he has no c/o [complaints of] pain. Has weakness in legs and requires assistance c transfers. Uses walker with supervision and wheelchair for long distances for safety. Alarm attached to cord for altered of fall prevention. Has some difficulty with speech. Speaks very little and answers questions with few words ... Dr. notified of assessment conducted. No new orders."</p> <p>f. A clinical document titled "Skilled Nursing Note" and dated on 5/16/12 and signed by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... fall prevention cord attached clothing ... incont [incontinent] care ... Fall prevention alarm cord attached clothing ... States his / her legs still feel weak. Speaks very little only answers c a few</p>						

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	<p>words. Instructed pt on Prozac use, action, se [side effects] Instructed pt on safety measures, fall prevention, how to call for help."</p> <p>g. The clinical document titled "Occupational Therapy Initial evaluation" with a signature of Employee V, OT on 5/16/12 stated, "Patient name #4 ... Treatment diagnosis functional decline ... decreased strength and balance to complete ADLs [Activities of Daily Living.]"</p> <p>h. A clinical document titled "Skilled Nursing Note" and dated on 5/21/12 and signed by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... fall prevention cord attached clothing ... incont [incontinent] care."</p> <p>3. The agency policy titled "Comprehensive Patient Assessment" with an effective date of 4/30/07 stated, "To determine the appropriate care, treatment and services to meet patient initial needs and his/her changing needs ... Reassessments are conducted based on patient needs, physician orders, professional judgement or other regulatory requirement."</p>				

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G0340	<p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.</p> <p>Based on clinical record review, document review, interview, and policy review, the agency failed to ensure a comprehensive assessment was completed after the patient returned home after hospitalization for 1 of 6 home visit observations (Clinical record #4.)</p> <p>Findings</p> <p>1. Clinical record #4, SOC 2/1/12 with a certification period of 4/1/12 - 5/30/12. failed to evidence a comprehensive assessment was completed when the patient returned from hospitalization after a fall that resulted in subdural hematoma. This was evidenced as follows:</p> <p>a. A clinical document titled "Fall Occurrence Report" and signed by Employee L on 4/27/12 stated, "Date of fall 4/27/12 reported by ALF RN, location of fall in Settler's House Room, Witnessed by aide - Settlers, Reported to [Employee L], Contributing factors poor</p>	G0340	G 0340 - All hospitalizations for patients will be tracked so that transfers and resumptions can be completed properly within a timely manner, entered, locked and submitted, and placed in the patients chart in a timely manner. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>decision making, Details of fall: what was the patient trying to do? Get up from chair ... physical therapy to eval .. notification given to DON, PT, POC [plan of care] reviewed." This was signed by the physician on 5/4/12.</p> <p>b. A clinical document titled "Skilled Nursing Note" and dated on 5/7/12 by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... Blood Pressure 160/76 ... States he was reaching for a shirt and fell few days ago. No apparent injury noted. Denies any pain. Instructed pt on home safety and emergency precautions."</p> <p>c. A clinical document titled "Care summary including oasis elements for transfer to inpatient facility" with Employee L's signature and date of 5/8/12 stated, "Emergent care injury caused by fall ... to which inpatient facility has the patient been admitted Hospital ... Reason for hospitalization 2 injury caused by fall date of last visit 5/7/12 ... reported from Settlers House pt fell while trying to get up ... patient tried to transfer without assistance."</p> <p>d. A clinical document titled "Hospital Physician Orders Patient transfer</p>				

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	<p>order form" was dated 5/11/12 and signed by the physician." The faxed cover sheet of this document was written to Incare on 5/11/12 from a ALF nurse and stated, "Readmit."</p> <p>e. A clinical document titled "Skilled Nursing Addendum" with a signature of Employee L on 5/12/12 stated, "head to toe assessment conducted. Pt has small hematoma on posterior head which he has no c/o [complaints of] pain. Has weakness in legs and requires assistance c transfers. Uses walker with supervision and wheelchair for long distances for safety. Alarm attached to cord for altered of fall prevention. Has some difficulty with speech. Speaks very little and answers questions with few words ... Dr. notified of assessment conducted. No new orders."</p> <p>f. A clinical document titled "Skilled Nursing Note" and dated on 5/16/12 and signed by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... fall prevention cord attached clothing ... incont [incontinent] care ... Fall prevention alarm cord attached clothing ... States his / her legs still feel weak. Speaks very little only answers c a few words. Instructed pt on Prozac use,</p>			

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	<p>action, se [side effects] Instructed pt on safety measures, fall prevention, how to call for help."</p> <p>g. The clinical document titled "Occupational Therapy Initial evaluation" with a signature of Employee V, OT on 5/16/12 stated, "Patient name #4 ... Treatment diagnosis functional decline ... decreased strength and balance to complete ADLs [Activities of Daily Living.]"</p> <p>h. A clinical document titled "Skilled Nursing Note" and dated on 5/21/12 and signed by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... fall prevention cord attached clothing ... incont [incontinent] care."</p> <p>2. The agency policy titled "Comprehensive Patient Assessment" with an effective date of 4/30/07 stated, "To determine the appropriate care, treatment and services to meet patient initial needs and his/her changing needs ... Reassessments are conducted based on patient needs, physician orders, professional judgement or other regulatory requirement."</p>						

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N0444	<p>410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions.</p> <p>Based on policy review, administrative document review, observation, personnel file review, and interview, the administrator failed to organize and direct the agency's ongoing functions for 1 of 1 home health agency the administrator was responsible for with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The administrator failed to ensure staff member files reviewed of staff hired prior to 6/12/11 had performance evaluations completed and direct care employees hired prior to January 1, 2012, attended professional inservices. (See N 446) 2. The administrator failed to ensure the agency met all the requirements for licensure. (See N 449) 3. The administrator failed to ensure the 	N0444	<p>N 0444 - The Administrator and DON have developed a tentative inservice schedule to ensure all professional staff attend all necessary inservices and to ensure the Aides have 12 hours of inservice education per year. The Administrator and DON have developed a tool to ensure performance evaluations are done for agencie's employees on an annual basis. The Administrator and DON have developed a plan and put into place this plan to ensure all employee medical records are kept and maintained appropriately and confidentially. Clinical staff have been inserviced on infection control practices and an infection control log will be maintained by the DON to ensure all infections are properly maintained and documented. The Administrator and DON will make sure that Registered Nurses and other disciplines involved in the wound care/dressing should coordinate with each other and get Doctor's</p>	07/18/2012			

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	<p>confidential medical records of employees were treated as confidential for 3 of 3 terminated employee records. (See N 466)</p> <p>4. The administrator failed to ensure staff implemented infection control practices. (See N 470)</p> <p>5. The administrator failed to ensure the personnel furnishing services implemented effective communication to promote the objectives in the plan of care. (See N 486)</p> <p>6. The administrator failed to ensure the patient rights had been provided to the the power of attorney, patients were treated with dignity while showering, and files were kept confidential. (See N 494, 496, 498, 500, 502, 504, 505, 506, 508, 514, and 518)</p> <p>7. The administrator failed to ensure the home health aide only performed tasks included on the plan of care and that the aide was able to perform. (See N 522)</p> <p>8. The administrator failed to ensure the plan of care included a timely physician signature. (See N 524)</p> <p>9. The administrator failed to ensure the registered nurse completed a</p>		<p>order for wound care/dressing. Tehy will do care coordination for any treatment done as well as the progress of the treatment and notify physician of any changes in the wound. The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and confidentially and not accessible by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin that is for shredding. The Administrator and DON have inserviced Home Heath Aide's on patient dignity to ensure that patients are properly covered while the patient is being showered/bathed. The Administrator and DON have inserviced staff on following the plan of care to ensure coordination of patient services occurs and that all staff are performing the appropriate tasks in which they are qualified to perform. The physician will be notified of any changes regarding treatment and/or changes in the</p>		

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	<p>comprehensive assessment to reevaluate the patient's needs after the patient returned home after hospitalization. (See N 541)</p> <p>10. The administrator failed to ensure the registered nurse maintained effective care coordination with the nurse providing dressing changes. (See N 545)</p> <p>11. The administrator failed to ensure the occupational therapist evaluated the patient's level of function after falls and complaints of pain. (See N 564)</p> <p>12. The administrator failed to ensure home health aides hired prior to 1/1/12 attended any hours of inservice in 2011. (See N 586 and 589)</p> <p>13. The administrator failed to ensure clinical records were maintained in accordance to professional standards. (See N 608)</p> <p>14. The administrator failed to ensure clinical records were safeguarded against unauthorized use. (See N 614)</p>		<p>patient condition and a verbal order will be obtained. The Agency will continue with its policy on clinical record review to ensure the plan of care is being followed and to ensure a timely physician signature is obtained. All hospitalizations for patients will be tracked so that transfers and resumptions can be completed properly within a timely manner, entered, locked and submitted, and placed in the patients chart in a timely manner. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>				

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N0446	<p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations.</p> <p>The administrator failed to ensure 11 of 11 staff member files reviewed of staff (files A, B, C, F, H I, J, K, L, P, and Q) hired prior to 6/12/11 had performance evaluations completed and 13 of 13 direct care employees hired prior to January 1, 2012, attended professional inservices (C, F, G, H, I, J, K, L, N, P, Q, R, and T).</p> <p>Findings</p> <p>1. On 6/28/12 at 2:45 PM the administrator indicated no inservices had been held in 2012 or 2011 with any personnel and no performance evaluations were completed in 2011 and 2012.</p> <p>2. The agency policy titled "Inservice Education /Staff Development" with an effective date of 4/30/07 stated, "All staff members providing direct client care will attend in-service education programs annually. These programs will be based on identified staff needs."</p>	N0446	N 0446 - The Administrator and DON have developed a inservice schedule to ensure all professional staff attend all necessary inservices and to ensure the Aides have 12 hours of inservice education per year. The Administrator and DON have developed a tool to ensure performance evaluations are done for agencies employees on an annual basis. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>3. The agency policy titled "Performance Evaluations" with an effective date of 4/30/07 stated, "A competency - based performance evaluation will be conducted for all employees after one year of employment and least annually thereafter."</p> <p>Personnel files lacking annual performance evaluations</p> <p>4. Personnel file A, date of hire (DOH) 2/5/09, lacked an annual performance evaluation.</p> <p>5. Personnel file B, DOH 2/19/09, lacked an annual performance evaluation.</p> <p>6. Personnel file C, DOH 7/19/10, lacked an annual performance evaluation.</p> <p>7. Personnel file F, DOH 11/9/08, lacked an annual performance evaluation.</p> <p>8. Personnel file H DOH 10/18/10, lacked an annual performance evaluation.</p> <p>9. Personnel file I, DOH 10/18/10, lacked an annual performance evaluation.</p> <p>10. Personnel file J, DOH 2/21/11, lacked an annual performance evaluation.</p>						

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	<p>11. Personnel file K, DOH 8/23/08, lacked an annual performance evaluation.</p> <p>12. Personnel file L, DOH 2/23/11, lacked an annual performance evaluation.</p> <p>13. Personnel file P DOH 4/1/09, lacked an annual performance evaluation.</p> <p>14. Personnel file Q, DOH 9/17/09, lacked an annual performance evaluation.</p> <p>Personnel files lacking inservice documentation</p> <p>15. Personnel file C, DOH 7/9/10, lacked documentation that the employee attended any inservices in 2011.</p> <p>16. Personnel file F, DOH 11/9/08, lacked documentation that the employee attended any inservices in 2011.</p> <p>17. Personnel file G, DOH 10/19/11, lacked documentation that the employee attended any inservices in 2011.</p> <p>18. Personnel file H, DOH 10/18/10, lacked documentation that the employee attended any inservices in 2011.</p> <p>19. Personnel file I, DOH 10/18/10, lacked documentation that the employee</p>				

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	<p>attended any inservices in 2011.</p> <p>20. Personnel file J, DOH 2/21/11, lacked documentation that the employee attended any inservices in 2011.</p> <p>21. Personnel file K, DOH 8/23/08, lacked documentation that the employee attended any inservices in 2011.</p> <p>22. Personnel file L, DOH 2/23/11, lacked documentation that the employee attended any inservices in 2011.</p> <p>23. Personnel file N, DOH 10/1/11, lacked documentation that the employee attended any inservices in 2011.</p> <p>24. Personnel file P, DOH 4/1/09, lacked documentation that the employee attended any inservices in 2011.</p> <p>25. Personnel file Q, DOH 9/17/09, lacked documentation that the employee attended any inservices in 2011.</p> <p>26. Personnel file R, DOH 10/25/11, lacked documentation that the employee attended any inservices in 2011.</p> <p>27. Personnel file T, DOH 10/25/11, lacked documentation that the employee attended any inservices in 2011.</p>				

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N0449	<p>410 IAC 17-12-1(c)(6) Home health agency administration/management Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (6) Ensure that the home health agency meets all rules and regulations for licensure.</p> <p>Based on policy review, administrative document review, observation, personnel file review, and interview, the administrator failed to ensure the agency met all the requirements for licensure for 1 of 1 home health agency the administrator was responsible for with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The administrator failed to organize and direct the agency's ongoing functions. (See N 444) 2. The administrator failed to ensure staff member files reviewed of staff hired prior to 6/12/11 had performance evaluations completed and direct care employees hired prior to January 1, 2012, attended professional inservices. (See N 446) 3. The administrator failed to ensure the 	N0449	<p>N 0449 - The Administrator and DON have developed a inservice schedule to ensure all professional staff attend all neccesarry inservices and to ensure the Aides have 12 hours of inservice education per year. The Administrator and DON have developed a tool to ensure performance evaluations are done for agencie's employees on an annual basis. The Administrator and DON have developed a plan and put into place this plan to ensure all employee medical records are kept and maintained appropriately and confidentially. Clinical staff have been inserviced on infection control practices and an infection control log will be maintained by the DON to ensure all infections are properly maintained and documented. The Administrator and DON will make sure that Registered Nurses and other disciplines involved in the wound care/dressing should coordinate with each other and get Doctor's order for wound care/dressing. Tehy will do care coordination for any treatment done as well as the progress of the treatment and</p>	07/18/2012			

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	<p>confidential medical records of employees were treated as confidential for 3 of 3 terminated employee records. (See N 466)</p> <p>4. The administrator failed to ensure staff implemented infection control practices. (See N 470)</p> <p>5. The administrator failed to ensure the personnel furnishing services implemented effective communication to promote the objectives in the plan of care. (See N 486)</p> <p>6. The administrator failed to ensure the patient rights had been provided to the the power of attorney, patients were treated with dignity while showering, and files were kept confidential. (See N 494, 496, 498, 500, 502, 504, 505, 506, 508, 514, and 518)</p> <p>7. The administrator failed to ensure the home health aide only performed tasks included on the plan of care and that the aide was able to perform. (See N 522)</p> <p>8. The administrator failed to ensure the plan of care included a timely physician signature. (See N 524)</p> <p>9. The administrator failed to ensure the registered nurse completed a</p>		<p>notify physician of any changes in the wound. The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and confidentially and not accessible by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin that is for shredding. The Administrator and DON have inserviced Home Heath Aide's on patient dignity to ensure that patients are properly covered while the patient is being showered/bathed. The Administrator and DON have inserviced staff on following the plan of care to ensure coordination of patient services occurs and that all staff are performing the appropriate tasks in which they are qualified to perform. The physician will be notified of any changes regarding treatment and/or changes in the patient condition and a verbal order will be obtained. The Agency will continue with its policy on clinical record review to</p>		

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	<p>comprehensive assessment to reevaluate the patient's needs after the patient returned home after hospitalization. (See N 541)</p> <p>10. The administrator failed to ensure the registered nurse maintained effective care coordination with the nurse providing dressing changes. (See N 545)</p> <p>11. The administrator failed to ensure the occupational therapist evaluated the patient's level of function after falls and complaints of pain. (See N 564)</p> <p>12. The administrator failed to ensure home health aides hired prior to 1/1/12 attended any hours of inservice in 2011. (See N 586 and 589)</p> <p>13. The administrator failed to ensure clinical records were maintained in accordance to professional standards. (See N 608)</p> <p>14. The administrator failed to ensure clinical records were safeguarded against unauthorized use. (See N 614)</p>		<p>ensure the plan of care is being followed and to ensure a timely physician signature is obtained. All hospitalizations for patients will be tracked so that transfers and resumptions can be completed properly within a timely manner, entered, locked and submitted, and placed in the patients chart in a timely manner. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>		

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N0466	<p>410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the:</p> <p>(1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k).</p> <p>Based on observation, document review, and interview, the agency failed to ensure the confidential medical records of employees were treated as confidential for 3 of 3 terminated employee records (Files Y, Z, and AA) and 1 of 24 records of active employees (Employee R).</p> <p>Findings include</p> <p>1. On 6/15/12 at 10 AM, many documents were observed on the window sill of 1 back office of the agency including 4 medical documents from terminated employees and 1 current employee.</p> <p>2. A physical examination of Y, a terminated contract physical therapist, was located on the window sill. This document titled "Physical Examination Record" with a date of 3/25/10 included the height and weight of the employee and current medications the employee</p>	N0466	N 0466 - The Administrator and DON have developed a plan and put into place this plan to ensure all employee medical records are kept and maintained appropriately and confidentially secured, locked in cabinet. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>was taking.</p> <p>3. A chest x ray of Z, a terminated contract physical therapist, was located in the window sill. This document titled "July 27, 2009 12:33 PM Family Practice page 1" stated, "Employee Z, medical record #, Date of birth, Status Final, Chest ... Clinical indication positive PPD ... "</p> <p>4. A document titled "A work status summary" from a health clinic described a visit of Employee R, home health aide, a current employee after a work-related illness and visit to the provider. This visit was dated 1/16/12.</p> <p>4. A document titled "Work Status Summary" with a date of 12/19/11 stated, "12-2-11 pt [patient] states she was giving a client a shower - he fell back and hit pt in the nose. Nose still hurts - gets headaches." This document is from the confidential medical file of Employee AA, HHA.</p> <p>5. On 6/15/12 at 10 AM, the administrator indicated the records above were not kept confidential.</p>						

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on clinical record review, policy review and interview, the agency failed to ensure staff implemented infection control practices for 5 of 12 records reviewed (patient 1, 4, 5, 6, 10, 12).</p> <p>Findings</p> <p>Regarding Barriers for Infection Control</p> <ol style="list-style-type: none"> On 6/13/12 at 8 AM, Employee F, home health aide, was observed to place the nursing bag on a chair without a barrier under the bag at patient #1's home prior to care. On 6/13/12 at 3 PM, Employee G, Registered Nurse (RN), was observed to place the nursing bag on a chair without a barrier under the bag at Patient #6's home. On 6/13/12 at 5 PM, Employee M, occupational therapist, was observed to place the equipment bag on a chair without a barrier under the bag at patient 	N0470	N 0470 - The Administrator and DON have inserviced staff on bag technique and using proper barriers for infection control practices. The Administrator and DON have developed an infection control log tool to ensure all infection's are properly documented and monitored. This log will be maintained at the Agency by the DON. Clinical staff have been inserviced on completing the medication profile and updating the medication profile not only every 60 days, but during the 60 day episode if any medication changes shall occur. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012	

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	<p>#2's room at an assisted living facility prior to care.</p> <p>4. On 6/14/12 at 11 AM, Employee J, Physical Therapist, was observed to place the equipment bag on a chair without a barrier under the bag at patient #5's home.</p> <p>5. On 6/15/12 at 10:50 AM, the administrator indicated no barriers were placed under the nursing bags for the above visits in findings 4 - 7.</p> <p>Regarding Infection Control Log</p> <p>6. The agency policy titled "Infection Control Surveillance" with an effective date of 4/30/07 stated, "An infection control log will be maintained."</p> <p>7. On 6/15/12 at 10:50 AM, the administrator indicated there was no infection control log.</p> <p>8. Clinical record #10, SOC 12/2/11 with a certification period of 3/31/12 - 5/29/12, included keflex 500 mg [milligram] po [by mouth] bid [twice a day] x 7 days on the medication profile dated 1/30/12. This antibiotic was listed as beginning on 1/30/12. There was no documentation in the infection log regarding this antibiotic.</p>				

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	9. Clinical record #12, SOC 1/12/12 with a certification period of 3/12/12 - 5/10/12, included an order for Cipro 500 mg bid X 14 days from a physician's office. There was no documentation in the infection log regarding this antibiotic.			

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N0486	<p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the personnel furnishing services implemented effective communication to promote the objectives in the plan of care for 1 of 6 patients reviewed (Clinical record #2) at home visit observations.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC) 4/19/12, included a plan of care for the certification period of 4/19/12 - 6/17/12 that failed to include an order for a wound dressing change on the left heel and coordination of care with the person changing the dressing. This was evidenced by the following:</p> <p>a. On 6/14/12 at 8 AM, Employee K, home health aide (HHA), indicated patient #2 had a dressing on the left heel for an abrasion. Employee K indicated he / she removed this dressing prior to showering the patient at HHA visits on 6/8/12 and 6/12/12. Employee K indicated the Employee L was aware of the abrasion. This patient lived in an assisted living and an assisted living nurse</p>	N0486	N 0486 - The Administrator and DON will make sure that Registered Nurses and other disciplines involved in the wound care/dressing should coordinate with each other and get Doctor's order for wound care/dressing. They will do care coordination for any treatment done as well as the progress of the treatment and notify physician of any changes in the wound. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>was changing this dressing.</p> <p>b. Clinical record #2 failed to indicate orders for the left heel dressing or any documentation concerning the left heel wound or dressing or a record that the dressing change was being done by the assisted living. The occurrence of the dressing removal by the aide was also not documented in the patient's clinical record or included on the aide care plan.</p> <p>2. The agency policy titled "Plan of Care" with an effective date of 4/30/07 stated, "An individualized Plan of Care signed by the physician shall be required for each patient receiving home health and personal care services. The Plan of Care shall be completed in full to include ... medications, treatments, and procedures ... all of the above items must always be addressed on the Plan of Care."</p> <p>3. The agency policy titled "Coordination of Patient services" with an effective date of 4/30/07 stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current Care plans and written and verbal interaction ... Interdisciplinary care</p>						

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	<p>conferences shall be conducted as often as necessary to respond to changes in the patient's needs, services, care, or goals ... Ongoing care conferences shall be conducted to evaluate the patient's status and progress. Any problems will be discussed and an action plan developed."</p> <p>4. On 6/15/12 at 1:50 PM, Employee C, the director of nursing, indicated the dressing and dressing removal were not included on the plan of care or included in coordination of care notes or other clinical documentation.</p>			

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N0494	<p>410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on clinical record review, interview, observation, and policy review, the agency failed to ensure that 1 of 12 clinical records (#10) had provided the patient rights to the the power of attorney and 2 of 12 patients were treated with dignity while showering (1 and 4).</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN, stated, "Verbal order</p>	N0494	N 0494 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the Patient Rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit. The Administrator and DON have inserviced Home Health Aide's on patient dignity to ensure that patients are properly covered while the patient is being showered/bathed. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. Regarding the patient being treated with dignity</p> <p>A. On 6/13/12 at 8:30 AM, Employee F, home health aide (HHA), was observed to give a shower to Patient #1. The shower failed to evidence the patient was treated with dignity as evidenced by the following:</p> <p>1). During the shower, Employee F failed to cover Patient #1 with a bath blanket or towel as the shower was completed. The patient was undressed and exposed with no covering for 5 minutes prior to the shower and 5 minutes after the shower was completed.</p>						

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	<p>2.) On 6/13/12 at 11:50 AM, Employee C, director of nursing (DON), indicated the patient was not covered during the observed shower and was not treated with dignity.</p> <p>B. On 6/14/12 at 9:30 AM, Employee K, HHA, was observed to give a shower to Patient #4. The HHA did not cover the patient after he/she was undressed for several minutes prior to the shower and after the shower. This visit failed to evidence this patient was treated with dignity as shown by the following:</p> <p>1.) During the undressing prior to the shower and dressing after the shower, the patient was undressed completely without a towel or bath blanket for dignity.</p> <p>2.) On 6/14/12 at 3:45 PM, the director of nursing indicated patient #4 was not covered for respect and privacy during the observed shower.</p> <p>3. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health</p>				

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	<p>agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>4. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of</p>						

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	furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."				

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N0496	<p>410 IAC 17-12-3(b) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (1) The patient's family or legal representative may exercise the patient's rights as permitted by law.</p> <p>Based on clinical record and policy and document review and interview, the agency failed to ensure the patient's power of attorney had been informed of the right to exercise his or her rights for 1 of 12 clinical records reviewed (Clinical record #10).</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was</p>	N0496	N 0496 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon initial visit. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse</p>				

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	<p>and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>				

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N0498	<p>410 IAC 17-12-3(b)(2)(A) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (A) Have his or her property treated with respect.</p> <p>Based on clinical record and policy and document review and interview, the agency failed to ensure the patient's power of attorney had been informed of the right of the patient to have his or her property treated with respect for 1 of 12 clinical records reviewed (Clinical record #10).</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was</p>	N0498	<p>N 0498 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit.</p> <p>The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012	

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	<p>not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse</p>				

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	<p>and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>			

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N0500	<p>410 IAC 17-12-3(b)(2)(B) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (B) Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so.</p> <p>Based on clinical record review, policy and document review, and interview, the agency failed to ensure the patient and / or patient's power of attorney had been informed of the right to voice grievances for 1 (#10) of 12 records reviewed.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to</p>	N0500	<p>N 0500 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit.</p> <p>The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012			

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	<p>dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home heath agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in</p>			

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	<p>planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>				

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N0502	<p>410 IAC 17-12-3(b)(2)(C) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency.</p> <p>Based on clinical record review, policy and document review, and interview, the agency failed to ensure the patient /patient's power of attorney had been informed of the state hotline number for 1 of 12 clinical records (Clinical record #10) reviewed.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of</p>	N0502	<p>N 0502 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit. The toll-free Home Health Hotline number will also be given upon admission to the patient/caregiver/legal guardian. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012	

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	<p>attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home heath agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment</p>				

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	... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity ... To be informed of the toll-free state hotline."			

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N0504	<p>410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished.</p> <p>Based on clinical record review, policy and document review and interview, the agency failed to ensure the patient /patient's power of attorney had been informed of the right to be informed in advance of the care to be furnished, the disciplines that would provide care, and the frequency of visits for 1 of 12 clinical records (Clinical record #10) reviewed.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p>	N0504	<p>N 0504 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon initial visit.</p> <p>The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012			

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	<p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or</p>				

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	<p>legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>				

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N0505	<p>410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment.</p> <p>Based on clinical record review, policy and document review and interview, the agency failed to ensure the patient /patient's power of attorney had been informed of the right to participate in planning the care or treatment and in planing changes in the care or treatment for 1 of 12 clinical records (Clinical record #10) reviewed.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of</p>	N0505	<p>N 0505 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012			

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	<p>Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or</p>			

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	<p>her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>			

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NAME OF PROVIDER OR SUPPLIER INCARE HOME HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 425 JOLIET ST STE 312 DYER, IN 46311
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N0506	<p>410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice.</p> <p>Based on clinical record review, policy and document review and interview, the agency failed to ensure the patient /patient's power of attorney had been informed of the right to be informed of any changes in the plan of care including reasonable discharge notice for 1 of 12 clinical records (Clinical record #10) reviewed.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p>	N0506	<p>N 0506 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit.</p> <p>The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012			

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	<p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the</p>						

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	<p>patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>				

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N0508	<p>410 IAC 17-12-3(b)(2)(E) Patient Rights Rule 12 Sec. 3(b)(2)(E) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records.</p> <p>Based on observation, interview, review of policies, and clinical documents, the agency failed to ensure the patient / patient's power of attorney was informed of the right to confidentiality of the medical records for 1 of 12 record reviewed (#10), the right to confidentiality was maintained for 6 of 6 patient documents (#13 - 18) observed on the floor and in window sills of the agency and 1 of 1 potential patient document (#19) found in the trash.</p> <p>Findings include</p> <p>1. On 6/15/12 at 10 AM, many documents were observed in two back rooms of the agency. These documents were located in piles and singly placed around these back rooms with other debris including food wrappers, paper clips, and pieces of paper. A document</p>	N0508	<p>N 0508 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit. The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and confidentially and not accessible by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin that is for shredding. (Space will be kept clean and free of clutter). The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012			

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	<p>from one record was located near the first door of the entrance to these back rooms. Another box of discharge records was placed by this door. In the second room, which was behind the first room, employee files of terminated employees and patient records were found located in window sills and on the floor in no apparent order. Outside the room in the main office, a referral from File #19 was found wadded up in the trash can of Employee E, an office assistant. Documents from Patient #s 13 - 18 were found in piles in the back two rooms of the agency and on the window sill, unsecured from view of anyone who entered the room.</p> <p>2. #13 evidenced a document titled "Staff Communication Note" and signed by Employee W, Registered Nurse (RN) on 3/12/12. This document stated, "Patient #13 communication regarding supervisory visit Narrative documentation. Did supervisory visit patient today and asked about his services ... Patient was consuming alcohol at time of visit."</p> <p>3. #14 evidenced a document titled "Fax" with a date of 2/23/12 with a sticky note on top of the record which stated, "Patient #14 for D/C file not most recent file her 8/3/11 SOC [start of care]chart and Employee E signature." This document</p>						

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	<p>stated, "Patient #14 9/29/11 Recertify home health cert ... Parkinson's, Incontinence, R/O UTI [rule out urinary tract infection] Bedbound, Prone to skin breakdown ... " This was signed by Employee P on 2/23/12.</p> <p>4. #15 evidenced a document titled "Care Summary including Oasis elements for transfer to inpatient facility" with a date of 8/15/11 and signed by Employee L. This document had a sticky note on top that stated, "D/C [discharge] done." This document stated, "Reason for hospitalization Respiratory infection."</p> <p>5. #16 evidenced a document titled "Oasis Care Summary including Oasis element for transfer to inpatient facility" and dated, "8/7/11 and signed by Employee P, RN. This document stated, "Clinical record items ... Pt up to BP [infers with bathroom or blood pressure] got dizzy, weak, 911 called. Pt with cardiac blockage 3 stents placed MI [myocardial infarction] noted Pt [patient] transferred to hospice care."</p> <p>6. #17 evidenced a document titled "Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 8/8/11 and signed by employee X stated, "Clinical record items ... Reason for admission to home health</p>			

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	<p>and summary of care to date pneumonia, HTN [hypertension] and incontinent."</p> <p>7. #18 evidenced a document titled "Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 6/25/11 and signed by employee P stated, "Clinical record items ... Reason for admission Patient back from LPH [Laporte Hospital] 6/24/11 This pt saw for ROC [resumption of care] 6/25/11 increased wheezing [SOB] confusion Dr. instructed pt. to ER agreed consider hospice referral. Family switching to VNA HHC [Visiting Nurse Association home health care] for easier transition to hospice past d/c LPH."</p> <p>8. #19 evidenced a document titled, "Fax" with the signature of Employee C, director of nursing, and date of 6/7/12 date. This document stated, "Patient #19 and patient's birth date. Skilled nurse to evaluate home health care services."</p> <p>9. On 6/15/12 at 10 AM, the administrator indicated the records above were not kept confidential.</p> <p>10. The agency policy titled "Clinical record confidentiality" with an effective date of 4/31/07 stated, "Clinical records will be stored in a locked cabinet or room. When in use, the record will be kept in a</p>			

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	<p>secure area and not left unattended in areas accessible to unauthorized individuals."</p> <p>11. The agency policy titled "Patient security and privacy" with an effective date of 4/30/07 stated, "Patient records and protected health information will be maintained in clinical records and on computers as needed."</p> <p>12. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p>			

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N0514	<p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on clinical record review, policy and document review, and interview, the agency failed to ensure the patient /power of attorney had been informed the agency must investigate complaints and must document both the existence and the resolution of the complaint for 1 of 12 records reviewed (patient #10).</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p>	N0514	<p>N 0514 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit.</p> <p>The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012			

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	<p>b. On 6/13/12 at noon, Employee A, administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home heath agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the</p>				

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	<p>patient rights as permitted by law ... the patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."</p> <p>3. The agency policy titled "Home Care Bill of Rights/Grievance Procedure" with an effective date of 4/30/7 stated, "Patients will be informed of their right to voice grievances and request changes ... To consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care, to protect and promote the exercise of patient rights ... a designated Registered Nurse / Therapist shall provide the patient with a written notice of the Home Care Bill of Rights in advance of furnishing care to the patient or during the initial evaluation visit before treatment is initiated. In the event the patient is unable to make decisions, the Home Care Bill of Rights shall be given to the patient's legal guardian."</p>				

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N0518	<p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record review, policy and document review, and interview, the agency failed to ensure the patient /patient's power of attorney had been informed of the agency's policies on advance directives and was provided a copy of state law for 1 of 12 clinical records (Clinical record #10) reviewed.</p> <p>Findings</p> <p>1. Clinical record #10, SOC 12/2/11, evidenced the patient rights were not signed by the patient's power of attorney.</p> <p>a. The clinical document titled "Admission Services Agreement" with a date of 12/2/11 and signature of Employee P, RN stated, "Verbal order ok'd [okayed] per [family member]."</p> <p>b. On 6/13/12 at noon, Employee A,</p>	N0518	<p>N 0518 - The Administrator and DON have inserviced staff regarding patient rights. Respective disciplines/case manager/RN will clearly explain the patient rights to the patient and/or the patient's appropriate caregiver/legal guardian and ensure they are signed by the appropriate person upon intial visit.</p> <p>The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012			

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	<p>administrator, indicated the patient was not able to sign the patient rights due to dementia and did have a power of attorney responsible for making the patient's decisions. This caregiver was not informed of the patient rights or requested to sign these documents.</p> <p>c. On 6/19/12 at 11 AM, the power of attorney for patient #10 indicated he /she had not signed the patient rights.</p> <p>2. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date noted stated, "The patient or the patient's legal representative has the right to informed of the patient rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: the home health agency shall provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The home health agency must maintain documentation showing that has complied with the requirements of this section ... The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient's family or legal representative may exercise the patient rights as permitted by law ... the</p>						

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	patient has the right to participate in the planning of care or treatment and in planning changes in the care or treatment ... The patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity ... have heath care providers comply with advanced directives in accordance with state law."				

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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 interview, clinical record review, and policy review, the agency failed to ensure the home health aide (Employee K) only performed tasks included on the plan of care and that the aide was able to perform for 1 of 9 active clinical records reviewed (Clinical record #2) with home health aide services with the potential to affect all patients receiving home health aide services.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC) 4/19/12, included a plan of care for the certification period of 4/19/12 - 6/17/12 that failed to include an order for a wound dressing change on the left heel.</p> <p>a. On 6/14/12 at 8 AM, Employee K, home health aide (HHA), indicated patient #2 had a dressing on the left heel for an abrasion. Employee K indicated he / she removed this dressing prior to showering the patient at HHA visit on 6/8/12 and 6/12/12. This patient lived in an assisted living and an assisted living nurse was changing this dressing.</p>	N0522	The Administrator and DON have inserviced staff on following the plan of care to ensure coordination of patient services occurs and that all staff are performing the appropriate tasks in which they are qualified to perform.	07/18/2012			

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	<p>Employee K indicated the Employee L, registered nurse, was aware of the abrasion.</p> <p>b. Clinical record #2 failed to include orders for the left heel dressing or any documentation concerning the left heel wound or dressing.</p> <p>2. The agency policy titled "Plan of Care" with an effective date of 4/30/07 stated, "An individualized Plan of Care signed by the physician shall be required for each patient receiving home health and personal care services. The Plan of Care shall be completed in full to include ... medications, treatments, and procedures ... all of the above items must always be addressed on the Plan of Care."</p> <p>3. On 6/15/12 at 1:50 PM, Employee C, the director of nursing, indicated the dressing and dressing removal were not included on the plan of care.</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 clinical record review, policy review, and interview, the agency failed to ensure the plan of care included a timely physician signature for 4 of 12 records reviewed (clinical record #1, #4, #7, and #11) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care (SOC) 1/12/12, included a plan of care for the 	N0524	<p>N 0524 - The physician will be notified of any changes regarding treatment and/or changes in the patient condition and a verbal order will be obtained. The agency will continue with its policy on clinical record review to ensure the plan of care is being followed and to ensure a timely physician signature is obtained. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012			

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	<p>certification period of 5/11/12 - 7/9/12 that failed to evidence a timely physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home health Certification and Plan of treatment" with a certification period of 5/11/12 - 7/9/12 was not signed by the physician.</p> <p>b. On 6/13/12 at 11:55 AM, Employee C, the director of nursing (DON), indicated the physician signature was not present.</p> <p>2. Clinical record #4, SOC 2/1/12, included a plan of care for the certification period of 4/1/12 - 5/30/12 that failed to evidence a timely physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home health Certification and Plan of treatment" with a certification period of 4/1/12 - 5/30/12 was not signed by the physician.</p> <p>b. On 6/14/12 at 3:20 PM, Employee C indicated the physician signature was not present.</p> <p>3. Clinical record #7, SOC 9/29/11,</p>				

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	<p>included a plan of care for the certification period of 1/27/12 - 3/26/12 failed to evidence a timely physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home health Certification and Plan of treatment" with a certification period of 1/27/12 - 3/26/12 was signed by the physician on 3/9/12.</p> <p>b. On 6/18/12 at 11 AM, Employee C indicated the physician signature was late.</p> <p>4. Clinical record #11, SOC 4/25/12, included a plan of care for the certification period of 4/25/12 - 6/23/12 that failed to evidence a physician signature. This was evidenced by the following:</p> <p>a. A clinical document titled "Home health Certification and Plan of treatment" with a certification period of 4/25/12 - 6/23/12 was not signed by the physician.</p> <p>b. On 6/13/12 at 12:40 PM, Employee S indicated the physician signature was not present.</p> <p>5. The agency policy titled "Physician Orders" with an effective date of 4/30/12</p>				

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	<p>stated, "All medications, treatments, and services provided to patients must be ordered by a physician the orders must be initiated via telephone or in writing and must be countersigned by the physician in a timely manner ... A system will be used by the agency to ensure the telephone orders are signed and dated by the physician and returned to the patient's clinical record within appropriate time frame."</p> <p>6. The agency policy titled "Plan of care" with an effective date of 4/30/12 stated, "An individual Plan of care signed by a physician shall be required for each patient receiving home health and personal care services ... The written Plan of Care shall be signed by the physician and returned to the agency ... Signed physician orders will be obtained as quickly as possible."</p>			

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N0541	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on clinical record review, document review, interview, and policy review, the agency failed to ensure the registered nurse completed a comprehensive assessment to reevaluate the patient's needs after the patient returned home after hospitalization for 1 of 6 home visit observations (Clinical record #4.)</p> <p>Findings</p> <p>1. Clinical record #4, SOC 2/1/12 with a certification period of 4/1/12 - 5/30/12. failed to evidence a comprehensive assessment was completed when the patient returned from hospitalization after a fall that resulted in subdural hematoma. This was evidenced as follows:</p> <p>a. A clinical document titled "Fall Occurrence Report" and signed by Employee L on 4/27/12 stated, "Date of fall 4/27/12 reported by ALF RN, location</p>	N0541	All hospitalizations for patients will be tracked so that transfers and resumptions can be completed properly within a timely manner, entered, locked and submitted, and placed in the patients chart in a timely manner.	07/18/2012	

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	<p>of fall in Settler's House Room, Witnessed by aide - Settlers, Reported to [Employee L], Contributing factors poor decision making, Details of fall: what was the patient trying to do? Get up from chair ... physical therapy to eval .. notification given to DON, PT, POC [plan of care] reviewed." This was signed by the physician on 5/4/12.</p> <p>b. A clinical document titled "Skilled Nursing Note" and dated on 5/7/12 by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... Blood Pressure 160/76 ... States he was reaching for a shirt and fell few days ago. No apparent injury noted. Denies any pain. Instructed pt on home safety and emergency precautions."</p> <p>c. A clinical document titled "Care summary including oasis elements for transfer to inpatient facility" with Employee L's signature and date of 5/8/12 stated, "Emergent care injury caused by fall ... to which inpatient facility has the patient been admitted Hospital ... Reason for hospitalization 2 injury caused by fall date of last visit 5/7/12 ... reported from Settlers House pt fell while trying to get up ... patient tried to transfer without assistance."</p>						

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	<p>d. A clinical document titled "Hospital Physician Orders Patient transfer order form" was dated 5/11/12 and signed by the physician." The faxed cover sheet of this document was written to Incare on 5/11/12 from a ALF nurse and stated, "Readmit."</p> <p>e. A clinical document titled "Skilled Nursing Addendum" with a signature of Employee L on 5/12/12 stated, "head to toe assessment conducted. Pt has small hematoma on posterior head which he has no c/o [complaints of] pain. Has weakness in legs and requires assistance c transfers. Uses walker with supervision and wheelchair for long distances for safety. Alarm attached to cord for altered of fall prevention. Has some difficulty with speech. Speaks very little and answers questions with few words ... Dr. notified of assessment conducted. No new orders."</p> <p>f. A clinical document titled "Skilled Nursing Note" and dated on 5/16/12 and signed by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... fall prevention cord attached clothing ... incont [incontinent] care ... Fall prevention alarm cord attached clothing ...</p>						

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	<p>States his / her legs still feel weak. Speaks very little only answers c a few words. Instructed pt on Prozac use, action, se [side effects] Instructed pt on safety measures, fall prevention, how to call for help."</p> <p>g. The clinical document titled "Occupational Therapy Initial evaluation" with a signature of Employee V, OT on 5/16/12 stated, "Patient name #4 ... Treatment diagnosis functional decline ... decreased strength and balance to complete ADLs [Activities of Daily Living.]"</p> <p>h. A clinical document titled "Skilled Nursing Note" and dated on 5/21/12 and signed by Employee L and the patient stated, "Homebound status taxing effort / needs assist to leave, confusion, weakness, unsafe to leave unassisted ... fall prevention cord attached clothing ... incont [incontinent] care."</p> <p>2. The agency policy titled "Comprehensive Patient Assessment" with an effective date of 4/30/07 stated, "To determine the appropriate care, treatment and services to meet patient initial needs and his/her changing needs ... Reassessments are conducted based on patient needs, physician orders, professional judgement or other</p>				

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N0545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on home visit observation, clinical record review, interview and policy, the agency failed to ensure the registered nurse (Employee L) maintained effective care coordination with the nurse providing dressing changes for 1 of 6 patients reviewed (Clinical record #2) at home visit observations.</p> <p>Findings</p> <p>1. Clinical record #2, start of care (SOC) 4/19/12, included a plan of care for the certification period of 4/19/12 - 6/17/12 that failed to include an order for a wound dressing change on the left heel and coordination of care for this treatment. This was evidenced by the following:</p> <p>On 6/14/12 at 8 AM, Employee K, home health aide (HHA), indicated patient #2 had a dressing on the left heel for an abrasion to the left heel. Employee K indicated he / she removed this dressing prior to showering the patient at HHA visits on 6/8/12 and 6/12/12. Employee</p>	N0545	<p>N 0545 - The Administrator and DON will make sure that Registered Nurses and other disciplines involved in the wound care/dressing should coordinate with each other and get Doctor's order for wound care/dressing. Tehy will do care coordination for any treatment done as well as the progress of the treatment and notify physician of any changes in the wound.</p> <p>The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>	07/18/2012			

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	<p>K indicated the Employee L, Registered Nurse, was aware of the abrasion. This patient lived in an assisted living and an assisted living nurse was changing this dressing. The record failed to evidence any communication with the nurse providing the dressing change.</p> <p>2. The agency policy titled "Coordination of Patient services" with an effective date of 4/30/07 stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current Care plans and written and verbal interaction ... Interdisciplinary care conferences shall be conducted as often as necessary to respond to changes in the patient's needs, services, care, or goals ... Ongoing care conferences shall be conducted to evaluate the patient's status and progress. Any problems will be discussed and an action plan developed."</p> <p>4. On 6/15/12 at 1:50 PM, Employee C, the director of nursing, indicated the dressing and dressing removal were not included on the plan of care or included in coordination of care notes or other clinical documentation.</p>				

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N0564	<p>410 IAC 17-14-1(c)(3) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (3) assist the physician, chiropractor, podiatrist, dentist, or optometrist in evaluating level of function;</p> <p>Based on home visit observation, policy review, and interview, the agency failed to ensure 1 of 1 contract occupational therapist (Employee M) evaluated the patient's level of function after falls and complaints of pain for 1 of 6 records reviewed of patients receiving occupational therapy (OT) services (patient #2) with the potential to affect all the agency's patient who received OT services.</p> <p>Findings include:</p> <p>1. On 6/13/12 at 4 PM, Employee M, occupational therapist, was observed at a occupational therapy visit with patient #2. This patient lived at an assisted living facility. Patient indicated had two falls in past two days (6/12/12 and 6/13/12) as patient was transferring from bed to wheelchair. Patient had a bruise on left cheek and left buttocks area that was visible between the shirt and pants worn and also painful knees. The occupational therapist did not do a skin assessment or other physical assessment before preceding to an observation of the</p>	N0564	The Administrator and DON will implement annual evaluations to the different agencies which involve the services of occupational therapist's to evaluate their competency and skills.	07/18/2012			

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	<p>patient's skills with transferring from recliner to wheelchair to bed despite the patient's complaints of pain in knees and bruising noted.</p> <p>2. The agency policy titled "Position: Occupational Therapist" with an effective date of 4/07 stated, "Provides services to home care clients in accordance with the Plan of Care. Services are provided under the direction of the attending physician with participation of the family and other members of the interdisciplinary team, as indicated ... Essential Functions/Areas of Accountability 1. Performs occupational therapy assessments, diagnostic tests, skilled treatments, and ongoing evaluation of clients who are receiving services under a medically approved Plan of Care. a. completes assessments in a timely manner and in accordance with Agency Policy ... c. Provides assessment findings and goals to assist in developing the client care plan and obtains specific physician orders as needed."</p> <p>3. On 6/15/12 at 1:50 PM, Employee C, the director of nursing indicated the occupational therapist did not evaluate the patient despite the patient's complaints of pain and bruising noted and report of additional falls on 6/12 and 6/13/12.</p>			

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N0586	<p>410 IAC 17-14-1(h) Scope of Services Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas:</p> <p>(1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff.</p> <p>(2) Observing, reporting, and documenting patient status and the care or service furnished.</p> <p>(3) Reading and recording temperature, pulse, and respiration.</p> <p>(4) Basic infection control procedures and universal precautions.</p> <p>(5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.</p> <p>(6) Maintaining a clean, safe, and healthy environment.</p> <p>(7) Recognizing emergencies and knowledge of emergency procedures.</p> <p>(8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property.</p> <p>(9) Appropriate and safe techniques in personal hygiene and grooming that include the following:</p> <p>(A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene.</p>						

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	<p>(F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance. (14) Any other task that the home health agency may choose to have the home health aide perform.</p> <p>Based on interview, document review, personnel file review, and policy review, the agency failed to ensure 3 of 3 home health aides hired prior to 1/1/12 (files F, K, and R) attended any hours of inservice in 2011.</p> <p>Findings</p> <ol style="list-style-type: none"> Review of agency documents failed to evidence any home health aide in service training had been conducted. Personnel files F, date of hire (DOH 11/9/08), K DOH 8/23/08, and R DOH 10/25/11 failed to evidence any inservice education had been completed. On 6/28/12 at 2:45 PM, the administrator indicated no inservices had been held in 2012 or 2011 with any personnel. The agency policy titled "Inservice Education /Staff Development" with an effective date of 4/30/07 stated, "All staff 	N0586	N 0586 - The Administrator and DON have developed a tentative inservice schedule to ensure all professional staff attend all necessary inservices and to ensure the Aides have 12 hours of inservice education per year. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	members providing direct client care will attend in-service education programs annually. These programs will be based on identified staff needs."				

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N0589	<p>410 IAC 17-14-1(i) Scope of Services Rule 14 Sec. 1(i) During a home health aide's first year on the state's home health aide registry, the number of hours of training for that aide shall be a prorated portion of the usual twelve (12) and eight (8) hours.</p> <p>Based on interview and review of policies and personnel files, the agency failed to ensure 1 of 1 home health aides hired prior to 1/1/12 (R) attended any hours of inservice in 2011.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Personnel file R, date of hire 10/25/11, failed to evidence the aide had completed any inservice education. 2. On 6/28/12 at 2:45 PM, the administrator indicated no inservices had been held in 2012 or 2011 with any personnel. Employee R, home health aide, date of hire 10/25/11 and first patient contact 10/26/11 did not attend any inservices. 3. The agency policy titled "Inservice Education /Staff Development" with an effective date of 4/30/07 stated, "All staff members providing direct client care will attend in-service education programs annually. These programs will be based on identified staff needs." 			N0589	<p>N 0589 - The Administrator and DON have developed a tentative inservice schedule to ensure all professional staff attend all necessary inservices and to ensure the Aides have 12 hours of inservice education per year. The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>		07/18/2012

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N0608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review, document review, observation, and interview, the agency failed to ensure clinical records were maintained in accordance to professional standards for 5 of 12 records reviewed (Clinical record #2 -5 and 11) and 6 of 6 former patient records (#13 - 18) and 1 of 1 potential patient document (#19).</p> <p>Findings</p> <p>Regarding professional standards</p> <p>1. On 6/15/12 at 10 AM, many</p>	N0608	N 0608 - The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and confidentially and not accessible by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin that is for shredding. (Space will be kept clean and free of clutter). The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.	07/18/2012			

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	<p>documents were observed in two back rooms of the agency. These documents were located in piles and singly placed around these back rooms with other debris including food wrappers, paper clips, and pieces of paper. A document from one record was located near the first door of the entrance to these back rooms. Another box of discharged records was placed by this door. In the second room which was behind the first room, patient records were located in window sills and on the floor in no apparent order. Outside the room in the main office, a referral from File #19 was found wadded up in the trash can of Employee E, an office assistant. Clinical records 13 - 18 were found in piles in the back two rooms of the agency and in the window sill.</p> <p>2. Clinical record #13 evidenced a document titled "Staff Communication Note" and signed by Employee W, Registered Nurse (RN) on 3/12/12. This document stated, "[Patient #13] communication regarding supervisory visit Narrative documentation. Did supervisory visit patient today and asked about his services ... Patient was consuming alcohol at time of visit."</p> <p>3. Clinical record #14 evidenced a document titled "Fax" with a date of 2/23/12 with a sticky note on top of the</p>						

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	<p>record which stated, "[Patient #14] for D/C file not most recent file her 8/3/11 SOC [start of care] chart and [Employee E's] signature." This document stated, "Patient #14 9/29/11 Recertify home health cert ... Parkinson's, Incontinence, R/O UTI [rule out urinary tract infection] Bedbound, Prone to skin breakdown ... " This was signed by Employee P on 2/23/12.</p> <p>4. Clinical record #15 evidenced a document titled "Care Summary including Oasis elements for transfer to inpatient facility" with a date of 8/15/11 and signed by Employee L. This document had a sticky note on top that stated, "D/C [discharge] done." This document stated, "Reason for hospitalization Respiratory infection."</p> <p>5. Clinical record #16 evidenced a document titled "Oasis Care Summary including Oasis element for transfer to inpatient facility" and dated, "8/7/11 and signed by Employee P, RN. This document stated, "Clinical record items ... Pt [patient] up to BP [infers with bathroom or blood pressure] got dizzy, weak, 911 called. Pt with cardiac blockage 3 stents placed MI [myocardial infarction] noted Pt transferred to hospice care."</p>				

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	<p>6. Clinical record #17 evidenced a document titled "Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 8/8/11 and signed by employee X stated, "Clinical record items ... Reason for admission to home health and summary of care to date pneumonia, HTN [hypertension] and incontinent."</p> <p>7. Clinical record #18 evidenced a document titled "Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 6/25/11 and signed by employee P stated, "Clinical record items ... Reason for admission Patient back from LPH [Laporte Hospital] 6/24/11 This pt saw for ROC [resumption of care] 6/25/11 increased wheezing [SOB] confusion Dr. instructed pt. to ER agreed consider hospice referral. Family switching to VNA HHC [Visiting Nurse Association home health care] for easier transition to hospice past d/c LPH."</p> <p>8. Clinical record #19 evidenced a document titled, "Fax" with the signature of Employee C, director of nursing and date of 6/7/12 date. This document stated, "[Patient #19] and patient's birth date. Skilled nurse to evaluate home health care services."</p>			

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	<p>9. On 6/15/12 at 10 AM, the administrator indicated the records above were not kept in accordance with professional standards.</p> <p>10. The agency policy titled "Clinical record confidentiality" with an effective date of 4/31/07 stated, "Clinical records will be stored in a locked cabinet or room. When in use, the record will be kept in a secure area and not left unattended in areas accessible to unauthorized individuals."</p> <p>11. The agency policy titled "Patient security and privacy" with an effective date of 4/30/07 stated, "Patient records and protected health information will be maintained in clinical records and on computers as needed."</p> <p>12. Clinical record #4, SOC 2/1/12 with a certification period 4/1/12 - 5/30/12, was missing the update to the comprehensive assessment prior to the above certification period. The missing recertification was found and placed in the clinical record. This document was dated 3/28/12 and signed by Employee L. This was evidenced by the following:</p> <p>On 6/14/12 at 3:45 PM, the director of nursing indicated the update to the comprehensive assessment was not</p>						

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	<p>present in the record.</p> <p>13. Clinical record #5, SOC 3/23/12 with certification periods of 3/23/12 - 5/21/12 and 5/22/12 - 7/20/12, was missing all physical and occupational therapy evaluations and visit notes.</p> <p>On 6/14/12 at 2:30 PM, the director of nursing indicated no physical therapy or occupational therapy visit notes or evaluations were in the clinical record. Visits and evaluations were missing from the start of care.</p> <p>14. Clinical record #11, SOC 4/25/12 with a certification period of 4/25/12 - 6/23/12, evidenced no nursing visit notes in the clinical record after 5/17/12. This was evidenced by the following:</p> <p>a. The Plan of care indicated the skilled nurse would visit once a week for 9 weeks.</p> <p>b. On 6/13/12 at 12:40 PM, the DON and administrator indicated no nursing notes were included in the clinical record.</p> <p>Regarding clinical records misfiled</p> <p>15. Clinical record #2, start of care 4/19/12 with a certification period of 2/17/12 - 4/19/12 - 6/17/12, included</p>				

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	<p>documents from another record. This was evidenced as follows:</p> <p>a. A clinical document titled "Steel Family Healthcare" with another patient's name and date of birth and visit date of 2/17/12 stated, "Patient comes in today basically to kind of clarify her pain medication ..." This was signed by a physician on 2/17/12.</p> <p>b. A clinical document titled "Quest Diagnostics" with another patient's name and identifiers stated, "Renal Function Panel Glucose 91 ... 2/21/12 letter of lab order sent JB."</p> <p>c. On 6/15/12 at 2 PM, the director of nursing (DON) indicated the above documents were from another patient's clinical records.</p>				

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N0614	<p>410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service.</p> <p>Based on observation, interview, review of policies, and clinical documents, the agency failed to ensure clinical records were safeguarded against unauthorized use for 6 of 6 patient records not reviewed (patients' 13 - 18) and 1 of 1 potential patient record (#19) observed on the floor and in window sills of the agency.</p> <p>Findings include</p> <p>1. On 6/15/12 at 10 AM, many documents were observed in two back rooms of the agency. These documents were located in piles and singly placed around these back rooms with other debris including food wrappers, paper clips, and pieces of paper. A document</p>			N0614	<p>N 0614 - The Administrator and DON have developed a plan and put into place this plan to ensure all clinical records are checked and maintained appropriately and confidentially and not accessible by unauthorized individuals. All documents with confidential information that are no longer needed will be placed in a bin that is for shredding. (Space will be kept clean and free of clutter). The Administrator and DON will be responsible to insure the deficiency is corrected and will continue to monitor so it does not recur in the future.</p>		07/18/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>from one record was located near the first door of the entrance to these back rooms. Another box of discharge records was placed by this door. In the second room, which was behind the first room, employee files of terminated employees and patient records were found located in window sills and on the floor in no apparent order. Outside the room in the main office, a referral from File #19 was found wadded up in the trash can of Employee E, an office assistant. Documents from Patient #s 13 - 18 were found in piles in the back two rooms of the agency and on the window sill, unsecured from view of anyone who entered the room.</p> <p>2. #13 evidenced a document titled "Staff Communication Note" and signed by Employee W, Registered Nurse (RN) on 3/12/12. This document stated, "Patient #13 communication regarding supervisory visit Narrative documentation. Did supervisory visit patient today and asked about his services ... Patient was consuming alcohol at time of visit."</p> <p>3. #14 evidenced a document titled "Fax" with a date of 2/23/12 with a sticky note on top of the record which stated, "Patient #14 for D/C file not most recent file her 8/3/11 SOC [start of care]chart and Employee E signature." This document</p>			

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	<p>stated, "Patient #14 9/29/11 Recertify home health cert ... Parkinson's, Incontinence, R/O UTI [rule out urinary tract infection] Bedbound, Prone to skin breakdown ... " This was signed by Employee P on 2/23/12.</p> <p>4. #15 evidenced a document titled "Care Summary including Oasis elements for transfer to inpatient facility" with a date of 8/15/11 and signed by Employee L. This document had a sticky note on top that stated, "D/C [discharge] done." This document stated, "Reason for hospitalization Respiratory infection."</p> <p>5. #16 evidenced a document titled "Oasis Care Summary including Oasis element for transfer to inpatient facility" and dated, "8/7/11 and signed by Employee P, RN. This document stated, "Clinical record items ... Pt up to BP [infers with bathroom or blood pressure] got dizzy, weak, 911 called. Pt with cardiac blockage 3 stents placed MI [myocardial infarction] noted Pt [patient] transferred to hospice care."</p> <p>6. #17 evidenced a document titled "Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 8/8/11 and signed by employee X stated, "Clinical record items ... Reason for admission to home health</p>			

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	<p>and summary of care to date pneumonia, HTN [hypertension] and incontinent."</p> <p>7. #18 evidenced a document titled "Oasis Care Summary including Oasis elements for transfer to inpatient facility" with a date of 6/25/11 and signed by employee P stated, "Clinical record items ... Reason for admission Patient back from LPH [Laporte Hospital] 6/24/11 This pt saw for ROC [resumption of care] 6/25/11 increased wheezing [SOB] confusion Dr. instructed pt. to ER agreed consider hospice referral. Family switching to VNA HHC [Visiting Nurse Association home health care] for easier transition to hospice past d/c LPH."</p> <p>8. #19 evidenced a document titled, "Fax" with the signature of Employee C, director of nursing, and date of 6/7/12 date. This document stated, "Patient #19 and patient's birth date. Skilled nurse to evaluate home health care services."</p> <p>9. On 6/15/12 at 10 AM, the administrator indicated the records above were not kept confidential.</p> <p>10. The agency policy titled "Clinical record confidentiality" with an effective date of 4/31/07 stated, "Clinical records will be stored in a locked cabinet or room. When in use, the record will be kept in a</p>				

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	<p>secure area and not left unattended in areas accessible to unauthorized individuals."</p> <p>11. The agency policy titled "Patient security and privacy" with an effective date of 4/30/07 stated, "Patient records and protected health information will be maintained in clinical records and on computers as needed."</p>				